

## CONSENT FORM FOR COLPOSCOPY, THERMAL ABLATION, CRYOSURGERY AND LEEP

I acknowledge that the clinician has given me all information and explained the colposcopy procedure, biopsy and the possible treatment options, risks and possible complications and has answered all my questions.

I hereby consent to colposcopy, biopsy/biopsies taken (if necessary), risks, complications and any treatment procedure recommended by the clinician.

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Patient's Name

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Signature

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Date

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Witness's Name

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Signature

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Date