



**LIMITED GUARANTEE FOR MESH PELVIC RECONSTRUCTIVE SURGERY
PATIENT ACKNOWLEDGMENT**

Saint Luke's Hospital of Bethlehem, Pennsylvania d/b/a St. Luke's Hospital & Health Network (St. Luke's) and The Institute for Female Pelvic Medicine & Reconstructive Surgery (IFPM) are offering to certain IFPM patients the opportunity to participate in a limited guarantee relating to pelvic reconstructive surgery utilizing mesh performed at St. Luke's. You are receiving this patient acknowledgment because you are eligible to participate. You can read the terms and conditions of the limited guarantee at www.mystlukesonline.org/pelvic-surgery/index.aspx. Alternatively, copies of the terms and conditions are available at IFPM upon request. **By signing below, you acknowledge that you have been given the opportunity to read the terms and conditions and to ask any questions you may have relating to the terms and conditions.**

In connection with the limited guarantee, St. Luke's and IFPM have developed and implemented at St. Luke's a multi-faceted care plan intended to direct the pre-operative and inpatient process for IFPM patients who undergo pelvic reconstructive surgery utilizing mesh at St. Luke's. As part of the care plan, and in order to participate in the limited guarantee, you must read the following information and then sign and print your name below. **By signing your name below, you are acknowledging that your urogynecologist and/or IFPM staff followed these portions of the care plan during your office visit(s):**

- Discussion of the following treatment options:
 - suture repair of your own tissue
 - use of vaginal support pessary
 - transabdominal mesh (open incision versus endoscopic placement)
- Surgical instruction booklet reviewed
- Medical clearance arranged
- Surgical procedure booked within three (3) business days after medical clearances obtained
- Cardiac or pulmonary consultations arranged at physician's discretion
- Pre-admission testing scheduled

PATIENT SECTION

I CERTIFY THAT THE ABOVE ELEMENTS OF THE CARE PLAN HAVE BEEN REVIEWED, DISCUSSED, OFFERED, PROVIDED, SCHEDULED AND/OR ARRANGED WITH/FOR ME.

I AGREE TO FOLLOW ALL PRE-OPERATIVE AND POST OPERATIVE INSTRUCTIONS GIVEN TO ME BY ST. LUKE'S, IFPM AND IFPM PHYSICIANS.

I HAVE ASKED OR BEEN OFFERED THE OPPORTUNITY TO ASK ST. LUKE'S, IFPM AND/OR THE IFPM PHYSICIANS ANY QUESTIONS CONCERNING THE GUARANTEE AND ITS TERMS (INCLUDING THE CARE PLAN) BEFORE SIGNING BELOW.

Signature: _____

Print Name: _____

WITNESS SECTION

Signature: _____

Print Name: _____