

**Dear patient, .....** (name), .....

Your gynecologist has recommended that you see a dysplasia consultation.

### **Reasons for this medical investigation could be:**

- Skin changes at the vaginal entrance, going along with skin discoloration and itching
- Noticeable cancer smear
- Infection with HPV
- Recurring bleedings after sexual intercourse
- Genital warts

## How does such a medical investigation work?

In general this medical investigation does not differ to an usual gynecological investigation. With a colposcope we are able to enlarge different scin areals. For example the vaginal entrance or cervix. If we see a noticeable change, we will investigate a small sample, maybe if necessary under local anesthesia. After evaluation we will inform your gynecologist.

## What should you pay attention to after?

In general you can continue your day without any restrictions. If we take a small sample, light bleedings can appear from one to three days. If you have any symptoms like fever or pains, please contact us or your gynecologist.

## What do we want to know before medical investigation?

First day of your last period .....

Do you tend to bleedings? No Yes

Do you have allergies?  No  Yes, .....

Do you take any medications? No Yes, .....

Please give your consent to this medical investigation with your signature:

Bamberg, the .....

patient Dr. med. Justine Dokoupil

Consent to data collection, processing and storage:

I hereby consent to the collection, processing and storage of my personal data for the purpose of consultation, examination, treatment and billing by the medical practice. I have understood and taken note of the patient information on data protection of the practice in accordance with the GDPR. I am aware, that I can revoke my consent in whole or in part at every time.

Date, signature: .....

**Release from medical confidentiality:**

I hereby give my consent for medical reports and findings to be sent to the referring / providing doctor, GP or external partners (e.g. cooperating laboratories) providing further treatment (e.g. e-Doctor's letter). To this end, I release Dysplasie Diagnostik Dokoupil treating me from their duty of medical confidentiality. I also authorize the practice to request the necessary findings from my family doctor, other specialists or clinics.

Date, signature: .....