[Your Clinic/Practice Name]
[Your Clinic/Practice Address]
[City, State, Zip Code]
[Phone Number]
[Email Address]
[Date]
[Patient's Name]
[Patient's Address]
[City, State, Zip Code]

Dear [Patient's Name],

Re: Consent for IUD Removal Procedure

We are writing to confirm your upcoming appointment for the removal of your Intrauterine Device (IUD). Please read the information below carefully, and indicate your consent by signing at the bottom.

Procedure Description:

The IUD removal procedure is a simple and quick process. It involves the gentle withdrawal of the device from the uterus through the cervix.

Potential Risks:

While the procedure is generally safe, there are some potential risks including:

- Discomfort or cramping
- Bleeding
- Infection
- Perforation of the uterus (rare)

Post-Procedure Care:

After the removal, you may experience mild cramping or bleeding. We recommend you follow the aftercare instructions provided at your appointment.

Consent:

I have read the information above regarding the IUD removal procedure, its risks, and the post-procedure care. I understand that I can ask any questions regarding the procedure and my healthcare provider will answer them.

By signing below, I consent to the removal of my IUD.

Patient Name: _____

Patient Signature: _____

Date: _____

If you have any questions before your appointment, please do not hesitate to contact our office.

Sincerely,

[Your Name]
[Your Title]
[Your Clinic/Practice Name]