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Informed Decision-Making Form

Your provider has recommended that you have a pap smear. It is recommended that all women should start getting a regular pap smear test at the age of 21.

What is a pap smear?

A pap smear is a screening test for cervical cancer. The pap smear looks for abnormal cells on your cervix that could turn into cervical cancer over time.

What are the benefits of having a pap smear?

The benefits of a pap smear include locating abnormal cells early so they can be treated before turning into cervical cancer, check your fertility, and check for other sexually transmitted infections.

What are the risks of having a pap smear?

The pap smear is not a perfect test, there may be a false negative possible, and some women may experience slight discomfort.

What are the benefits of having a colorectal screening test?

Colon cancer is usually a very slow growing cancer. If colon cancer is caught early, a better outcome is expected.

What are the alternatives?

Cervical cancer often does not cause symptoms until it is advanced, so it is important to get screened whenever you feel healthy.



I have been given educational information about cervical cancer screening. Initial: _____

I am refusing to have a pap smear at this time. Initial: _____

I agree that I have read this whole document and that I was given the opportunity to discuss the benefits of the recommended care and the risks of not getting the care with my provider who has answered all of my questions.

Even knowing all of this, I have decided at this time not to get the recommended colorectal cancer screening test. I know that my decision not to follow my provider's recommendations may endanger my health or my life.

I know that I may change my decision and have the recommended tests and/or treatments at any time in the future.

Date: ____/____/____ Time: _____ (AM) (PM)

Signature of Patient or Authorized Individual: _____

Relationship of Authorized Individual: _____

Provider's Name: _____

Provider's Signature: _____

Witnessed By: _____

Name of Patient: _____ Date of Birth: ____/____/____