

OFFICE PROCEDURE CONSENT FORM

Procedure: Sonohysterogram

Indications: Endometrial abnormality on ultrasound, infertility, preoperative evaluation of uterine lining, etc.

Alternative Treatments: Hysteroscopy, dilatation and curettage, endometrial biopsy, no further testing.

Risks: Bleeding, cramping, discomfort, minor or major infections. Rarely, these could require hospitalization and/or additional surgery. Occasionally, the procedure will be diagnostic only; where no disease is present or the disease is inoperable. Additionally, the test may be inconclusive.

Other: \_\_\_\_\_

I have read and understand the potential risks and benefits. All of my questions regarding the procedure have been answered to my satisfaction and I desire to proceed with the procedure.

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Witness Signature

\_\_\_\_\_  
Print Patient Name

\_\_\_\_\_  
Physician Signature

\_\_\_\_\_  
Date