



## **CONSENT FOR HYSTEOSALPINGOGRAM**

A hysterosalpingogram has been recommended for me.

The nature and purpose of the procedure, its potential benefits and risks, the likely outcome without the procedure, and the available alternatives have been explained to me.

In summary, I understand that during this procedure, radio-opaque contrast (“dye”) will be injected into my uterine cavity and fallopian tubes to observe them under fluoroscopy (“X-ray”), and that the purpose is to determine whether my uterine cavity is normal in size and shape and/or whether my fallopian tubes are open. A short course of antibiotics has been recommended to minimize the risk of a pelvic infection. The risks of the procedure include, but are not limited to:

- 1) Pelvic infection (1%), particularly if the tubes have a pre-existing infection, possibly resulting in pelvic adhesion formation and subsequent infertility;
- 2) Allergic reaction to the dye and/or antibiotics, resulting in hives and/or breathing difficulty (<0.1%);
- 3) Perforation of the uterus, resulting in bleeding (<0.1%);
- 4) Exposure of fetus to X-ray and dye and possible miscarriage, if the procedure is inadvertently carried out during a pregnancy (<0.1%).

Additional comments, if any:

I am aware that there may be other risks and complications not discussed that may occur. I also understand that during the course of the procedure, unforeseen conditions may be revealed requiring the performance of additional procedures. I acknowledge that no guarantees or promises have been made to me concerning the results of this procedure or any treatment that may be required as a result of this procedure.

I understand what has been discussed with me as well as the contents of this form. I have been given the opportunity to ask questions and have received satisfactory answers.

I, the undersigned, understand the above explanation and accept the risks associated with undergoing a hysterosalpingogram. I consent to the performance of the procedure as described above by my physician and/or my physician’s delegated associates.

Patient Name (please print): \_\_\_\_\_ Date: \_\_\_\_\_

Patient’s Signature: \_\_\_\_\_

Witness Name (please print): \_\_\_\_\_ Date: \_\_\_\_\_

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

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