South Sound Radiologists, Inc., P.S.

INFORMED CONSENT
HYSTEROSALPINGOGRAM

Washington State law guarantees that you have both the right and obligation to make decisions concerning your healthcare. Your clinician (physician or healthcare provider) can provide you with the necessary information and advice, but as a member of the health care team, you must enter into the decision making process. This form has been designed to acknowledge your acceptance of treatment recommended by your clinician.

Patient: _____ **Patient** #:_____

I hereby authorize Dr._____ and/or such associates or assistants as may be selected by the aforementioned physician to perform a **HYSTEROSALPINGOGRAM.**

PROCEDURE: A special x-ray dye (contrast) is injected through a small catheter placed into the uterus. X-ray images are taken of the uterus and fallopian tubes to check function.

RISKS: I understand all procedures carry some risk. We (your referring clinician and radiologist) would not recommend this procedure unless we believed the advantages far outweighed the disadvantages. However, you must understand and accept the potential risks. The potential risks include, but are not limited to: abdominal pain, cramping, bleeding, pelvic infection, allergy or adverse reaction to x-ray dye (contrast), or injury to the uterus. If you are pregnant at the time of this procedure, there is risk of abortion or injury to the fetus. Therefore, a pregnancy test is required prior to this exam. Although these risks and complications occur rarely, they do occur and cannot be predicted. I acknowledge that no guarantee has been made to me about the results of this procedure.

BENEFITS: Possible diagnosis of gynecological problems, such as fallopian tube blockage.

ALTERNATIVES TO PROCEDURE: No further testing versus other medical tests such as hysteroscopy, hysterosonogram or laparoscopy depending on clinical history.

You always have the right to refuse any procedure at any time. It is your responsibility to inform us if you do not want the procedure or wish to stop the procedure after it has started. It is also your responsibility to inform us of any prior adverse outcome or reaction to a similar study or x-ray dye.

I certify that the nature and character of this proposed procedure and the anticipated benefits involved in this proposed procedure have been explained to me. I recognize that during the course of this procedure, post-operative care, medical treatment, anesthesia, or other procedure, unforeseen conditions may necessitate additional or different procedures than those set forth. I have been informed that various equipment and instrumentation may be used during my procedure. I therefore, authorize the above-named physician, and his or her assistants or designees, to perform such procedures as in his or her professional judgment are necessary and desirable. The authority granted under this paragraph shall extend to the treatment of all conditions that require treatment and are not known to my physician at the time the medical procedure is commenced.

I certify that this form has been fully explained to me, that I have read it, or have had it read to me, and I understand its contents.

_____ _____

Patient/Other Legally Responsible Person Signature Date Time

_____

Witness