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CONSENT FOR DIAGNOSTIC OFFICE HYSTEROSCOPY

_____
Patient Name (Print)

I have explained to the patient the nature of her condition, the nature of the procedure, and the benefits to be reasonably expected with alternative approaches.

Hysteroscopy is performed to find out the cause of disorders that may arise from the lining of the uterus (i.e. polyps, fibroids, adhesions).

I have discussed the liklihood of major risks or complications, including:

1. Bleeding
2. Infection
3. Perforation of the uterus
4. Cramping of the uterus, causing discomfort

I also understand that with any procedure there is always the possibility of an unexpected complication and no guarantees or promises can be made concerning the results of any procedure or treatment.

All questions were answered and the patient consents to the procedure.

_____
Signature of physician

Dr. _____ has explained the above to me and I consent to the proceedure.

_____ _____
Date and Time Patient Signature

Time Out - Non OR setting: Verification of correct patient, prodedure side, site, position, equipment and implants was completed, as applicable, just prior to performance of the procedure.

_____ _____
Date Clinician Signature