Hirsch & Ratakonda M.D.

Hysterosalpingogram

Patient Name: ______________________________ MR #: ____________________

Date: ______________________________________

1. I hereby authorize Dr. __________________ and/or such assistants as may be selected by he/she to perform the procedure of Hysterosalpingogram.
2. The nature of this procedure or treatment, possible methods of treatment, the risks involved and the possibilities of complications have been explained to me by Dr. ______. These risks include, but are not limited to: infection, allergic reaction, bleeding and uterine perforation.
3. I am aware that the practice of medicine and surgery is not an exact science and I acknowledge that no guarantees have been made to me as to the results of the operation, procedures, or treatments.

Signature: ____________________________

Date: ________________________________

Witness: ______________________________

TIME:

# of Images:

Doctor:	RX:
Age:	Allergies:
Pregnancy:	LMP:
U/S:	Cycle:
SX:	PID:
PCOS:	Prior HSG?:
Clomid:	Metformin: