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SONOHYSTEROGRAM

PATIENT NAME: _____ MR#: _____

DATE: _____

1. I hereby authorize Dr. _____ and/or such assistants as may be selected by him/her to perform the procedure of **Sonohysterogram**.

2. The nature and purpose 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 or bleeding.

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.

4. ALLERY TO LATEX: YES _____ NO _____

SIGNATURE: _____ RELATIONSHIP: _____

DATE: _____ TIME: _____

WITNESS: _____