



THE CENTER FOR HUMAN REPRODUCTION (CHR)—ILLINOIS/NEW YORK CITY*
TRANSCERVICAL CATHETER PROCEDURE
Description, Explanation and Informed Consent

I hereby authorize Dr. _____ and whoever may be designated as the assistants to perform the following procedure(s) as described below:

- **Hysterosalpingogram with possible Tubal Catheterization**—An X-ray of the uterus and fallopian tube(s) with possible attempt to open blocked fallopian tube(s) using pressure and/or wire guidance.

I understand that other procedure(s) may be indicated necessary based upon the findings during the course of this office procedure(s).

I consent to the administration of sedation as ordered by the physician if the use of such sedatives is designated necessary with the exception of the following: _____

I have notified the CHR staff of any allergies I have which include: _____

I understand the risks of the procedure may include:

- Infection
- Uterine perforation
- Heavy bleeding

The nature and purpose of the procedure, possible alternative methods of treatment, risks involved and the possibility of complications have been fully explained to me. No guarantee or assurance has been given by anyone as to the results that may be obtained.

I do hereby sign and consent to pay any charges incurred prior to or during this procedure. It is my understanding that there is a direct charge for the procedure itself, and that there may be a separate charge for consultation and/or laboratory charges. In the occurrence that the insurance carrier denies my eligibility or coverage for these services, I will be fully responsible for the remittance of all fees.

I certify that I have read and fully understand the above consent to this procedure, and that all explanations referred to were made, and that all blanks or statements requiring insertion or completion were filled in before I signed. In addition, I hereby certify that I have been given the opportunity to have any/all questions answered to my satisfaction. The alternative diagnostic/therapeutic interventions that are alternatives to this procedure have also been explained to me, and I have elected to proceed.

Date

Signature of Patient

Patient Name-Print

As one of the staff members of The Center for Human Reproduction by my signature indicate that the foregoing consent was read, discussed and signed in my presence.

Date

Signature of Witness

Witness Name-Print

* Per NY State Law doing business as the Medical Offices for Human Reproduction (MOHR)
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04/24/2001