



**THE CENTER FOR HUMAN REPRODUCTION (CHR)—ILLINOIS/NEW YORK CITY\***  
**OVARIAN CYST ASPIRATION**  
**Description, Explanation and Informed Consent**

I hereby consent to undergo ovarian cyst aspiration. I understand that this is done through the use of a vaginal ultrasound probe that has a special needle located along the side of the probe. This needle goes through the vaginal wall and aspirates the fluid from the cystic structure located in or on the ovary. I understand that some of the possible risks of ovarian cyst aspiration are, but are not limited to:

1. Damage to adjacent structures.
2. Bleeding and/or infection.
3. Reoccurrence of the ovarian cyst.
4. Adverse effects of anesthesia or analgesics.

I hereby consent to the administration of such anesthetics as may be considered necessary or advisable by my physician with the exception of: \_\_\_\_\_

I do hereby sign and consent to pay any charges incurred related to this procedure. It is my understanding that there is a direct charge for the procedure itself and that there may be a separate sedation charge, consultation fee 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 remittance of all fees.

Allergies: \_\_\_\_\_

**I acknowledge that all of my questions concerning this procedure have been answered.**

<b>Date</b>	<b>Signature of Patient</b>	<b>Patient Name-Print</b>
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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.

<b>Date</b>	<b>Signature of Witness</b>	<b>Witness Name-Print</b>
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\* Per NY State Law doing business as the Medical Offices for Human Reproduction (MOHR)  
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