

# HOBOKEN RADIOLOGY

*Providing a clearer image of health*

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## SONOHYSTEROGRAM CONSENT FORM

### PATIENT INFORMED CONSENT FOR SONOHYSTEROGRAM

I, \_\_\_\_\_ am \_\_\_\_\_ years old and I am NOT  
*(Patient Name -please print clearly)* *(Patient Age)*  
pregnant. I am aware and understand that if I am pregnant and have this procedure, I could very well have a miscarriage or harm the fetus.

I understand the above and hereby release Hoboken Radiology, LLC, the attending physician, its personnel and employees, from any responsibility whatsoever for any harmful effects I may incur or affects my fetus may incur as a result of this procedure, if in fact I am pregnant. I understand further that this RELEASE shall be binding upon my heirs, executors, administrators and assigns.

The benefits, alternatives and risks of this procedure have been explained to me to my satisfaction and understanding. All questions regarding this procedure have been answered.

I give my consent to having the SONOHYSTEROGRAM performed.

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Physician Signature

\_\_\_\_\_  
Witness Signature

### WHEN PATIENT IS A MINOR OR OTHERWISE UNABLE TO SIGN ON HER OWN BEHALF

\_\_\_\_\_  
Name of Legally Authorized Representative  
*(Please print clearly)*

\_\_\_\_\_  
Signature of Legally Authorized Representative

\_\_\_\_\_  
Relationship to Patient  
*(Please print clearly)*

\_\_\_\_\_  
Reason for Patient's Incapacity  
*(Please print clearly)*

\_\_\_\_\_  
Witness Signature