

Hysteroscopy Procedure

A Hysteroscopy procedure shows the direct visualization of the uterine cavity with lighting and magnification through a long, pencil sized telescope. It aids in diagnosing abnormal uterine bleeding and/or uterine problems.

I authorize Dr. _____, and such health professionals in training and assistants that he/she may select, to perform a Hysteroscopy procedure under local anesthesia performed here at SWHC.

I confirm that my doctor has advised me about my condition, the nature and benefits of the proposed treatment, alternatives, and related risks associated with Hysteroscopy. The risks may include but or not limited to infection, bleeding and/or treatment failure.

I was given an explanation of any unfamiliar terms and was offered the opportunity to ask questions regarding the Hysteroscopy procedure. I understand my post-op instructions and realize this is an important part of my recovery plan.

Patient Signature: _____

Date: _____

Witness: _____

Interpreter Attestation (when applicable):

Name of interpreter used during informed consent discussion: _____