טופס הסכמה: צילום רחם

CONSENT FORM: HYSTEROGRAPHY

Hysterography is carried out for diagnosis of abnormalities of the uterus and tubes in cases of fertility problems, that is inability to become pregnant or maintain pregnancy. In order to perform the examination, an instrument that holds and steadies the cervix of the uterus is used. A thin tube is inserted through the cervix and through it radiographic contrast medium containing iodine is injected. Thereafter the uterus is scanned radiographically and a number of X-ray photographs are taken.
The examination is performed after the end of menstruation (in the first half of a menstrual cycle) without anesthesia.
If the last period has been different from the usual, the physician should be notified before the examination in order to rule out pregnancy.

If allergy to iodine is known, the physician and the radiographer must be notified.

Name of Woman: _____ _____ _____ _____
Last Name First Name Father's Name ID No.

I hereby declare and confirm that I received a detailed verbal explanation from:
Dr. _____ _____
Last Name First Name
regarding hysterography, its purpose and method of performance (henceforth: "the primary examination").

I declare and confirm that I have received an explanation that during the performance of the primary examination, pain in the pelvis and abdomen (because of contractions of the uterus) is usually expected. This may continue for a short while after the examination, and there may also be vaginal bleeding of no significant quantity.

I have also received an explanation concerning the possible risks and complications including: infection, recurrence of chronic pelvic infections, an allergic reaction of varying degree to the contrast medium, and in rare cases perforation of the uterus.

It has also been explained to me and I understand that in cases of severe infection or perforation of the uterus during the examination it is possible that the need will arise to perform repair procedures, in order to save my life or prevent physical harm, including additional surgical procedures that cannot be fully or definitely predicted at this time, but whose significance has been made clear to me, including the need, rarely, to excise the uterus.

I hereby give my consent to perform the primary examination.

I know, confirm and agree that the primary procedure or any other procedure will be performed by whoever is designated to do so, according to the institutional procedures and directives, and that there is no guarantee that they will be performed, fully or in part, by a certain person, as long as they are performed according to the institution's standard degree of responsibility and according to the law.

_____ _____ _____
Date Time Patient's Signature

Name of Guardian (Relationship)	Guardian's Signature (for incompetent, minor or mentally ill patients)

I hereby confirm that I provided the patient / the patient's guardian* with a detailed verbal explanation of all the above mentioned, as required, and that he/she signed the consent form in my presence after I was convinced that he/she fully understood my explanations.

Name of Physician	Physician's Signature	License No.

* Cross out irrelevant option.