NEWLIFE FERTILITY CENTRE	Title: Sonohysterogram Patient Consent File Name US-4000-Sonohysterogram Patient Consent-V1

Patient Name: _____

DOB: _____

Chart#: _____

Date of the procedure: _____

Location: _____

***It is recommended to take Advil 600mg with Tylenol 1,000mg together (if no allergies) 1-2hr prior to appointment time.**

***Fasting is not required for this procedure and driving is permitted.**

I,_____, patient of NewLife Fertility Centre, hereby consent to undergo the procedure of Sonohysterogram at NewLife Fertility Centre. I understand that during this procedure, the doctor may also have either or all of the following taken; a Vaginal Swab, PAP Test and/or Endometrial Biopsy.

I was explained the nature and reason of doing the procedure. I was also informed of the possible complications after the procedure which can include pain, bleeding, fever, and unusual vaginal discharge. There is also a less than 0.4% risk of developing Pelvic Inflammatory Disease which is inflammation of the upper genital tract (fallopian tubes, uterus and/or ovaries) that can cause severe infection, tubal damage and may require hospitalization. I was given instructions to contact NewLife Fertility Centre immediately if the above symptoms or any adverse reactions develop and if severe, are aware to go to a local Emergency Department at the closest hospital near me.

Nurse contact information during clinic hours: 905-896-7100 ext 193
After hours emergency line (3pm-8pm): 289-242-1540

I give my consent to have this procedure done by ANY doctor, regardless of whether they are my originally designated doctor.

Patients Signature: _____

Date: _____