EASTSIDE DIAGNOSTIC IMAGING, PLLC

PLEASE READ AND SIGN

Patient Consent For Invasive Procedure

DATE OF SERVICE: REFERRING PHYSICIAN/PHONE NUMBER:

PATIENT NAME: SOCIAL SECURITY #: Account Number:

DOB: AGE:

IF YOU ARE PREGNANT, PLEASE NOTIFY THE TECHNOLOGIST IMMEDIATELY

I hereby consent to and authorize Eastside Diagnostic Imaging, PLLC, its doctors, technicians and medical personnel to perform a **Hysterosonography on (insert date of exam).**

I have completed the patient questionnaire and provided all the information with regard to my medical history.

The nature and purpose of this prodecure have been explained to me. I understand that there will be a flexible tipped catheter inserted into my body.

The risks of injury, infection, bleeding and other complications, despite all precaution have been explained to me. All questions that I may have in reference to this procedure and its associated risks have been explained to my satisfaction.

Signature of Patient or Guardian or person authoized to consent for this patient

Date

If for any reason following this procedure you experience discomfort or other symptoms. please call our office at 212-888-1000 ext 1512 or call your referring physician.

For office use only:

Signature of Radiologist

Date

Signature of technologist

Date

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