

## SONOHYSTEROGRAPHY PATIENT INFORMATION

### TAKE THREE ADVIL ONE HOUR PRIOR TO TEST TO MINIMIZE ANY DISCOMFORT

Your doctor has referred you to our clinic for a sonohysterogram. This ultrasound examination provides considerable information about the lining of your uterus and potency of the fallopian tubes, without the use of x-ray, x-ray dye or an anesthetic.

Indications for this are numerous and may include abnormal vaginal bleeding, infertility, miscarriages, any suspected abnormalities of the uterus, or as a preliminary evaluation for in-vitro fertilization. You will likely have had preliminary ultrasounds of your pelvis before the test.

The procedure itself takes 10-15 minutes. A thin catheter is placed through the cervix into the uterus. Normal saline (a salt-water solution) is instilled through the catheter in order to allow us to see the inside of the uterus and check the fallopian tubes, if necessary.

During the procedure you may feel some cramping as the catheter is inserted. Following the procedure, you may experience a watery vaginal discharge for a couple of hours. After the test, relax in our office for about 15 minutes and then you may resume normal activities. Please telephone your doctor in one week for the results.

There is a low risk of infection for this procedure. A sterile technique is maintained for this test. However, if you notice increased pelvic pain with or without vaginal discharge and fever, please contact your doctor immediately or go to the closest emergency room.

This recently developed diagnostic test is performed without the use of radiation and does not require anesthetic. It has become the "gold standard" in assessing the causes of uterine bleeding and infertility.

**Special Instructions:** If you are on blood thinners, please consult your doctor prior to your Sonohysterogram if you can stop your blood thinners. If you are able to stop your blood thinner prior to your Sonohysterogram, could you please send us your INR results from one day before your appointment.

## CONSENT TO TREATMENT FOR A SONOHYSTEROGRAPHY

I, \_\_\_\_\_ consent to an ultrasound examination.  
*Printed name of patient/substitute decision maker*

I confirm that the risks, side effects, alternative courses of action, material effects and consequences of having or not having the proposed treatment have been discussed with me and that \_\_\_\_\_ has responded to my questions.  
*Name of Health Practitioner*

\_\_\_\_\_  
*Printed name of patient/  
substitute decision maker*

\_\_\_\_\_  
*Signature of patient/  
substitute decision maker*

\_\_\_\_\_  
*Date*

\_\_\_\_\_  
*Printed name of witness*

\_\_\_\_\_  
*Signature of witness*

\_\_\_\_\_  
*Date*

I confirm that the above information has been discussed with the patient/substitute decision maker. I have responded to any and all questions about the proposed treatment, alternative courses of action, material effects, risks and side effects and consequences of not having the treatment.

\_\_\_\_\_  
*Signature of Health Practitioner proposing treatment*

\_\_\_\_\_  
*Date*