the Toronto Centre for Medical Imaging

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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*