Herzliya Medical Center

טופס הסכמה : היסטרוסקופיה אבחנתית
Consent Form: Diagnostic Hysteroscopy

Diagnostic hysteroscopy is a procedure which enables direct view of the uterine cavity in order to diagnose problems and anatomic pathologies of the uterine cavity. To perform a hysteroscopy the uterine cavity must be expanded using a physiologic fluid. A diagnostic hysteroscopy is usually carried out without anesthesia. The decision to use one of the types of anesthesia or a combination of the two is at the discretion of the performing doctor. The examination may be carried out in the community clinic or at a hospital.

Name of Woman: _____ (Last Name) _____ (First Name) _____ (Father's name) _____ (Date of Birth) _____

_____ (Identity/Passport No.) _____ (Address) _____ (Telephone No.)

I hereby declare and confirm that I received a detailed verbal explanation from:

_____
Name of Physician

regarding the need carry out a diagnostic hysteroscopy (hereinafter: the "Main Procedure").
I hereby declare and confirm that the side effects of the Main Procedure have been explained to me, including: abdominal pains, slight discomfort, and hemorrhaging which normally subside within a few hours.
The possible rare complications and risks have been explained to me, including: infection, hemorrhaging, and a piercing of the uterus which may necessitate, in very rare cases, a remedial operation. In even rarer cases, an infection or piercing of the uterus may necessitate a hysterectomy. In addition, in extremely rare cases there may be injury to other abdominal organs, a complication which may necessitate remedial surgery.
I hereby give my consent to carry out the Main Procedure.
In addition, I hereby declare and confirm that it has been explained to me and I understand that it is possible that during the Main Procedure it may turn out that it must be expanded, changed or that other lifesaving or damage preventing procedures should be taken, including surgical

procedures, which cannot be certainly or fully anticipated, but their meanings have been clearly explained to me. Therefore, I hereby agree to said expansion, change, or performance of other or additional procedures, including surgical actions, which the institution's doctors find necessary during the Main Procedure.
My consent is also granted for the performance of local anesthesia and provision of sedatives, having been explained the risks and complications of local anesthetics, including: different degrees of allergic reactions to the anesthetics and possible reactions to the sedatives provided, which may, in rare cases, have side effects which affect the respiratory system and the heart especially with heart and respiratory system patients. If it is decided that the Main Procedure is to be performed under general anesthetics I will be provided with an explanations regarding the anesthetics by an anesthesiologist.
I am aware of and consent to having the Main Procedure and all other procedures conducted by whomever may be charged with doing so, in accordance with the procedures and instructions of the institute and I was not promised that they would all or part thereof be conducted by a certain person, so long as they are done with the customary warranty established in the hospital or ambulant medical institution and as stipulated by current legislation.

Date	Time	X Patient's Signature

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

I hereby confirm that I have orally explained to the patient / the patient's guardian* all of the above with the necessary specifications and that she/he have signed this consent before me having been convinced that she understood my explanations in full.

Name of Physician	Physician's Signature	License No.

*Delete the unnecessary