One Boston Medical Center Place
Boston, MA 02118

Consent to Special Procedure

I, ______________________________, hereby authorize my physician, dentist or surgeon in charge, Shruthi Mahalingaiah MD (MD NAME) together with such assistants as he/she may designate, to perform the following special procedure.

Flexible hysteroscopy (NAME OF PROCEDURE), Evaluating inside of the womb with a camera (BRIEF DESCRIPTION/EXPLANATION IN LAY TERMS)

Risks include bleeding, infection, injury to internal organs including perforation of the uterus

and such additional operations or procedure as are considered necessary on the basis of findings during the course of said special procedure. Any tissues or parts surgically removed may be disposed of by Boston Medical Center in accordance with accustomed practice.

The nature, extent, and purpose of the operation, possible alternative methods or treatment, the risks involved, and the possibility of complications have been fully explained to me. I acknowledge that no guarantee has been made as to the results that may be obtained.

I understand that a blood transfusion may be necessary, and I hereby consent to the transfusion of blood/blood products. I have received an explanation of risks, benefits and alternatives to a transfusion. (Cross out if not applicable.)

I certify that I have read and fully understand the above consent, that explanations have been made, and that the physician, dentist or surgeon has answered all of my questions.

DATE	PATIENT AND/OR
(PHYSICIAN SIGNATURE)	RESPONSIBLE RELATIVE or GUARDIAN
PRINT NAME	RELATIONSHIP