TRANSVAGINAL SCAN - INFORMED PATIENT CONSENT

| Patient Name: |  |
| --- | --- |
| Patient Date of Birth: |  |
| Patient Telephone Number: |  |

Please check as appropriate:

I have previously had a Transvaginal Ultrasound procedure:

* Yes
* No

I am/have been sexually active:

* Yes
* No

**Patient Information**

Your doctor has requested us to perform a transvaginal ultrasound. It is important that you understand the procedures that are associated with this examination:

* The ultrasound transducer (a sterilised probe) will be placed in the vagina.
* The transducer will be introduced with a non latex covering that will have a small amount of lubricating gel applied to make it easier to put inside you.
* If you prefer, you may insert the transducer yourself, otherwise the Sonographer conducting the examination will do this.
* It will be necessary to move the transducer from side to side, up and down or to use rotational movements to obtain images.
* A chaperone may be present during the examination if required by the Sonographer or requested by yourself
* You may request the examination to be stopped at any time during the examination

**Risks and Complications of a Transvaginal Ultrasound**

There are no known risks of performing a transvaginal ultrasound. It is normal to feel mild pain and discomfort during a transvaginal ultrasound scan. If screening is performed over an area of tenderness, you may also feel some pressure. If the scan causes you anything other than mild pain, please let the Sonographer know.

**Patient Consent**

* I acknowledge that the Sonographer has explained the proposed procedure and/or provided me with information regarding the proposed procedure.
* I understand the risks and complications involved in the procedure.
* I understand I have the right to change my mind at any time including after I have signed this form to stop the procedure prior to completion of the procedure.
* I have been provided the opportunity to have any questions answered. I give my consent for the transvaginal examination to be performed.

| Patient Name (Print) | Patient Signature | Date |
| --- | --- | --- |
| Sonographer (Print) | Sonographer Signature | Date |
| Chaperone (if applicable) | Chaperone Signature | Date |