



LENOX HILL RADIOLOGY &  
MEDICAL IMAGING ASSOCIATES P.C.

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# HYSTEROSONOGRAM PROCEDURE

## PREPARATION

Studies must be performed within 10 days of the first day of the menstrual cycle but after your period is over and bleeding has stopped.  
If your bleeding lasts 2 weeks please discuss procedure with your physician.  
Please refrain from intercourse from the time your period begins until after the exam is performed so there is no chance of pregnancy. If there is any chance you may be pregnant please perform a pregnancy test prior to the procedure.  
Please inform us if you have a history of Pelvic Inflammatory Disease (PID).

## PROCEDURE

1. A sonogram will initially be performed.
2. A Radiologist will be performing the procedure. The doctor will insert a speculum into the vagina. The area will then be cleansed with betadine (a liquid soap)
3. A catheter will be inserted through the speculum into the cervix.
4. A tiny balloon at the tip of the catheter will act as a stopper while fluid is injected into the endometrium. This fluid will allow us to better visualize the uterine cavity and lining.
5. The sonographer will then re-insert the probe and document any findings.

## POST HYSTEROSONOGRAM INSTRUCTIONS

1. In the majority of cases, there is no discomfort except for mild cramping.
2. For relief, take Tylenol. Avoid aspirin-based products and other nonsteroidal anti-inflammatory medications (e.g., Advil, Motrin, Ibuprofen) as they may contribute to bleeding.
3. Nothing should be inserted into the vagina for 24 hours.
4. Avoid heavy lifting or exercise for 24 hours.
5. In the event that you develop fever, pain (greater than normal menstrual pain), or excessive bleeding, please contact your doctor directly. This may be a sign of infection.

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CT SCAN-MULTIDETECTOR HEART SCAN VIRTUAL COLONOSCOPY DENTAL SCAN	DIGITAL X-RAY FLUOROSCOPY	ULTRASOUND HDI MAMMOGRAPHY BONE DENSITOMETRY	MRI/MRA OPEN MRI HIGHFIELD 1-5T 3T MRI/MRA	BREAST MRI BIOPSY ULTRASOUND BIOPSY FINE NEEDLE ASPIRATION	PET/CT CT/MR FUSION NUCLEAR MEDICINE RADIATION ONCOLOGY
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## CONSENT FOR PROCEDURE

Patient:

Date:

Time:

a.m./p.m.

1. I hereby authorize the radiologist to perform upon me the following procedure. If any unforeseen condition arises in the course of the procedure calling their judgement for procedures in addition to or different from those contemplated, I further request and authorize them to do whatever they deem advisable.
2. The nature and purpose of this procedure, possible alternative methods of treatment, the risks involved, and the possibility of complications with respect to the procedure and administration of medications have been explained to me. I acknowledge that no guarantee or assurance has been made as to the results obtained.
3. I hereby certify that I have read and fully understand the preceding consent to perform this procedure and that the explanations therein referred to were made.

**Signature of Patient:**

**Witness:**