

Patient Name

Patient Identifier

CONSENT FOR PELVIC EXAMINATION

A Pelvic Examination is an examination of the vagina, cervix, uterus, fallopian tubes, ovaries, rectum, or external pelvic tissue or organs. This procedure is used to diagnose and/or treat conditions that involve the pelvis. It may be performed using any combination of modalities, which may include the health care provider’s gloved hand or instrumentation. For purposes of this consent, vaginal sonography is included.

By signing below, the undersigned agrees and authorizes the organization and Providers named below to perform a pelvic examination, including vaginal sonography, as described above.

Practice/Organization Name: _____

Providers (names of individuals performing the examination)

Provider Name	Provider Name
➤ _____	➤ _____
➤ _____	➤ _____
➤ _____	➤ _____

I agree that I have been given the opportunity to refuse to give such consent and that I may withdraw my consent at any time during my appointment.

_____ Date: _____ Time: _____

Patient Signature

IF PATIENT IS UNABLE TO CONSENT COMPLETE THE FOLLOWING:

This patient, whose name is written about, is unable to consent to and execute this document for the following reason: _____

I hereby execute this document on the patient’s behalf. I have read and fully understand each part of this document. I represent and verify that I am authorized to execute this document on behalf of the patient named above. I understand that I am entitled to receive a signed copy of this document.

Signature of patient representative

Relationship to patient

Date: _____

Time: _____