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# Consent for Transvaginal / Transrectal Ultrasound Examination

Patient Label Here  
(Affix MRN label)

I acknowledge that the procedure, Transvaginal / Transrectal Ultrasound Examination, has been explained to me. I understand this procedure, and I give my consent to have it performed.

## I CONSENT to have this procedure performed

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**Patient's Name:** \_\_\_\_\_

**Patient's Signature:** \_\_\_\_\_

**Date:** \_\_\_\_\_

**Technologist's Signature:** \_\_\_\_\_

**Date:** \_\_\_\_\_

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## I DO NOT WISH to have this procedure performed

**Patient's Signature:** \_\_\_\_\_

**Date:** \_\_\_\_\_

*Your privacy and comfort are important to us. You may ask questions at any time, and you may request that a chaperone be present during your examination. Reports are interpreted by qualified professionals and sent to your referring physician.*