1. I hereby authorize Doctors _________________________________________________________________, (Attending and Resident or Fellow)

and such other associates as may be selected by attending doctor to perform upon

_______________________________________________________ the following diagnostic or therapeutic

(myself or name of patient)

procedure ________________________________________, which involves the use of x-rays.

(technical name followed by description in lay language)

2. I understand that this procedure involves the use of x-rays which will irradiate my baby.

   a. The estimated dose to the fetus (baby) is less than 5 rem.

   b. Radiation of the fetus (baby) at this dose level is associated with minimally increased risk of
      childhood cancer

All of my questions concerning the risks and benefits of this procedure have been answered to my
satisfaction. I am aware that the practice of medicine is not an exact science and I acknowledge that no
 guarantees have been made to me regarding the outcome of this pregnancy.

Signature _________________________________, _________________________________

(Patient or person authorized to consent for the patient) (Relationship if not the patient)

I declare that I have personally explained to _____________________________ the

(Patient or representative)

nature of the patient’s condition and why this test is needed on __________ at __________ AM/PM

(Date) (Time)

Signature ________________________________________________________________

(Signature of Physician)