CONSENT FOR OPERATION OR PROCEDURE

Imaging of the Abdomen or Pelvis in Pregnancy

Dose = > 5 REM

Monitored Telephone Consent recorded electronically via Epic

Dotted lines to be completed by patient or representative as applicable.

1. I hereby authorize Doctors ____________________________, (Attending and Resident Physician[s]/Dentist[s]) to perform the procedure described below upon myself/the patient, as named above. I understand that the attending doctor may select Residents, Medical Students, and other medical personnel to perform important parts of the surgery and/or administer anesthesia, and they will perform only those tasks within their scope of practice.

Procedure: (no abbreviations)
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

2. The nature of my/the patient’s condition, the nature and purpose of the operation/procedure, anticipated benefits, possible alternative methods of treatment, risks involved, and possible consequences and complications have been explained to me.

   A. This procedure involves the use of x-rays which will irradiate my baby.

   B. The estimated dose to the fetus (baby) is greater than 5 rem.

   C. Radiation of the fetus (baby) at this dose level is associated with very minimally increased risk of:
      1. Childhood cancer.
      2. Congenital abnormality.
      3. Mental retardation and small head size.

3. In the event developments indicate that further operations/procedures may be necessary, I authorize the physicians to use their own judgment and do as they deem advisable during the operation/procedure for my/the patient’s best interests. Note any exceptions:

4. I agree to the administration of anesthesia/sedation as deemed necessary for my procedure.

5. Should I/the patient have an Advance Directive/Do Not Resuscitate (DNR) order, I understand that it may be temporarily suspended during this procedure. I will discuss any questions with my physician.

6. I am aware that the practice of dentistry, medicine, and surgery is not an exact science and acknowledge that no guarantees have been made to me by anyone regarding the outcome of this pregnancy.

Signature: ___________________________ Date: ___________________________

(Patient or person authorized to consent for patient)

I declare that I have personally explained to the patient, or their representative, the nature of the patient’s condition, the procedures to be undertaken, the benefits, risks and alternatives. Date: ___________________________ Time: ___________________________

(Signature/Title of Physician/Dentist/PA/ARNP) (Printed name of Physician/Dentist/PA/ARNP) (CLP#)