Consent Form for Imaging of the Abdomen or Pelvis in Pregnancy where the Dose is Greater than 50mSv (5 rem)

Department of Radiology

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

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

__________________________, (myself or name of patient)

the following diagnostic or therapeutic 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. Radiation of the fetus (baby) substantially above this dose level is associated with increased risk of:

1. Childhood cancer
2. Congenital abnormality
3. Mental retardation and small head size
4. Miscarriage (only associated with radiation doses greater than 200 mSv.)

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)