G-2d2 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.
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1. I authorize ____________________________, to perform the procedure described below
(Attending and Resident Physician[s]/Dentist[s], PA[s], ARNP[s])

upon myself/the patient, as named above. The University of Iowa Hospitals and Clinics is a teaching institution dedicated to
the training of the next generation of health care providers. Various members of the health care team will be involved in the
procedure and certain portions might be performed by trainees. I understand that the attending health care provider may
select Residents, Fellows, and other appropriately licensed and privileged medical personnel to perform parts of the
procedure and/or administer anesthesia, and they will perform only those tasks within their scope of practice. The attending
health care provider will be present and participate in the critical or key portions of the procedure.

Procedure: (no abbreviations and include laterality as applicable) Imaging of the Abdomen or Pelvis in Pregnancy where
the dose is >5 rem – This procedure involves the use of x-rays which will irradiate my baby. The estimated radiation dose to
the baby is greater than 5 rem.

2. The nature of my/the patient’s condition, the nature and purpose of the operation/procedure, anticipated benefits, possible
alternative methods of treatment, known risks involved in either the operation/procedure or of not having the operation or
procedure, if any, and possible consequences and complications have been explained to me.

RISKS: Radiation of the baby at this dose level is associated with 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 concerning the results of the outcome of this pregnancy.

_________________________________________________            _____________________________________________
(Signature/Title of Physician/Dentist/PA/ARNP)                                                                        (Printed name of Physician/Dentist/PA/ARNP)
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)