G-2d$_2$ CONSENT FOR OPERATION OR PROCEDURE **Imaging of the Abdomen or Pelvis in Pregnancy** **Dose = 1-5 rem** Monitored Telephone Consent recorded electronically via Epic *Dotted lines to be completed by patient or representative as applicable.* **Page 1 of 1** •This completed form must be scanned in Epic•	DATE HOSP.# NAME BIRTH DATE IF NOT IMPRINTED, PLEASE PRINT DATE, HOSP. #, AND NAME

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 = 1-5 rem** – This procedure involves the use of x-rays which will irradiate my baby. The estimated radiation dose to the baby is less 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 childhood cancer.

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 _ **Date** _ _ _ _ _ _ _ _ _ _ _ _ _ _
(Patient or person authorized to consent for patient)

_ _
(Printed name of person signing if not the patient) (Relationship to 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)