The IMAGING CENTER at COOKEVILLE REGIONAL
The Proven Choice

PREGNANCY QUESTIONNAIRE CONSENT

ALL FEMALES BETWEEN THE AGES OF 10 AND 55
COMPLETE THIS FORM BEFORE YOUR EXAMINATION

It is recognized that *ionizing radiation* can be harmful to a fetus. It is the policy of The Imaging Center at CRMC that females who are pregnant or suspect that they are pregnant should not have an exam that utilizes ionizing radiation unless the referring physician and/or radiologist determine the exam is medically necessary. The Imaging Center at CRMC requires confirmation of pregnancy/non-pregnancy for females of childbearing age prior to performing a radiological exam. Childbearing age is considered to be between 10-55 years.

VISITORS

❑ I am not pregnant and have chosen to enter the scan/exam room with the patient_____ *(Visitor Initials)*

***For the privacy and safety of our patients, visitors are not allowed in the room for some exams.**

_____ _____
Visitor Signature Date/Time

PATIENT

NEGATIVE PREGNANCY STATUS:

❑ I am not pregnant _____ *(Patient Initials)*

Pregnancy may be confirmed with a urine test at the patient's expense.
If you are pregnant or suspect you may be pregnant, your options are as follows:

UNCLEAR PREGNANCY STATUS

❑ I have decided to reschedule the exam/procedure until my pregnancy status is confirmed. The Imaging Center will notify my physician of the delay of my exam.

❑ I have declined a pregnancy test and have decided to proceed with my examination.

❑ I have had a pregnancy test and the results indicate that:

❑ I am pregnant _____ *(Patient Initials)* ❑ I am not pregnant _____ *(Patient Initials)*

POSITIVE OR UNCLEAR PREGNANCY STATUS

The possible risk vs. benefit for the exam/procedure has been explained to me. I have been given the opportunity to ask questions about the proposed imaging procedure and its risks and alternatives. I have sufficient information to give this informed consent. The form has been explained to me, I have read it or had it read to me, and I understand its contents. At this time I have:

❑ I have read and fully understand the above and hereby give my consent to have an X-ray, CT or Nuclear Imaging procedure performed. (I have been informed of the estimated risks to my embryo or fetus. _____) *(Patient Initials)*

❑ Declined to undergo the exam/procedure _____ *(Patient Initials)*

By signing below, I agree that the above statements are true and assume responsibility for my decision to undergo the exam/procedure.

Pt Name (print)

MR #

PLACE PATIENT ID STICKER
IF AVAILABLE

_____
Patient/Guardian Signature

_____
Date/Time

_____
Technologist/Nurse Signature

_____
Date/Time