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X-ray / CT / MRI Pregnancy Consent

Name ______________________________ **Date of Birth** ____________________

Referring Physician ____

Must be completed for / or by all women between the ages of 11-50.

The radiation used in X-Ray, fluoroscopy, and CT may be harmful to an unborn child. To help prevent the accidental irradiation of an unrecognized pregnancy, and in accordance with national standards, we required the following information from female patients of childbearing age. If any of the information below indicated even the remote possibility of pregnancy, your referring physician will be asked to order a urine or serum pregnancy test prior to any imaging.

Please answer the following questions:

1.) Are you, or is it possible that you might be pregnant? ☐ Yes or ☐ No or ☐ Unsure

2.) Are you currently breastfeeding? ☐ Yes or ☐ No

3.) Method of Birth Control: ______________________________________

If you are not currently on birth control, have you had sexual activity since your last menstrual period that may put you at risk for pregnancy? ☐ Yes or ☐ No or ☐ Unsure

4.) First day of last menstrual period (LMP)? ______________________________

I, (patient or responsible party) have been fully informed of the risks involved in radiating a first trimester pregnancy and assume the responsibility for any consequences from the procedures I am about to have. I also will not hold Back Bay Imaging and/or the employees of the facility responsible for any potential harm to my unborn child or myself.

______________________________ ____________________

SIGNATURE* DATE

*Patient or Patient Representative: Parent/Conservator/Guardian