Mount Sinai Hospital

Department of Radiology of the Mount Sinai Health System

The Mount Sinai Hospital | Mount Sinai Brooklyn | Mount Sinai St. Luke's | New York Eye and Ear Infirmary of Mount Sinai | Mount Sinai Doctors Faculty Practices

Mount Sinai Beth Israel | Mount Sinai Queens | Mount Sinai West

PRE-PROCEDURAL PREGNANCY ASSESSMENT & TESTING WAIVER

Including determination of who must undergo pregnancy testing before imaging tests/procedures

Name: _____

Date of Birth: ____/____/____ Insurance Gender: _____ Gender Identity: _____

Requesting Physician: _____

Today's Date: ____/____/____

Med Rec Num: _____ (if known) Accession: _____ (if known)

Section A

The Department of Radiology requires a pregnancy test for patients of childbearing potential before certain imaging procedures, including magnetic resonance imaging, use of x-rays/gamma rays, or intravenous contrast ("dye").

1. If any of the following conditions apply, patients may skip directly to the waiver in Section B:

SKIP TO WAIVER

- ❑ less than 12 years old and has not had first menstrual period;

  OR
- ❑ has not menstruated within the past 12 months;

  OR
- ❑ has had uterus removed, or both ovaries removed, or has undergone bilateral tubal ligation ("tubes tied").

2. If none of the three conditions above applies, it is Mount Sinai Department of Radiology policy that patients of childbearing potential receive pregnancy testing before certain procedures.

   2b. Please indicate the date your last complete menstrual period began: ____/____/____ (Mo / Day / Yr)

   2a. Is there any possibility you could be pregnant?
   - □ Yes → *Pregnancy test is required*
   - □ Uncertain → *Pregnancy test is required*
   - □ No → *If absolutely certain, you may waive testing*

Section B
WAIVER OF PREGNANCY TESTING

Mount Sinai policy requires a pregnancy test in patients of childbearing potential before certain imaging procedures. A patient who meets the criteria in question #1 above may sign the waiver below. A patient who does not meet these criteria may also waive this pregnancy test requirement if she understands the risks of doing so.

By New York State law and Mount Sinai policy, only patients aged 18 years or older may sign a pregnancy testing waiver. A parent or guardian may not sign for a minor.

1. *I understand that methods of contraception may not be 100% effective in preventing pregnancy.*
2. *I understand the nature and purpose of the proposed pregnancy testing. I have been informed that there may be risks and consequences to me or an unborn child of not proceeding with the testing, including but not limited to possible miscarriage, premature delivery, malformation or damage to the fetus, or medical complications of the procedure that would adversely affect me, the pregnancy, or the unborn child.*
3. *I hereby release Mount Sinai Health System and its facilities, employees, students, medical staff and trustees from any liability for ill effects that may result to me or an unborn child from failure to undergo pregnancy testing.*
4. *I have had the opportunity to ask questions about the testing, and all of my questions have been answered to my satisfaction.*
5. *By signing below, I choose not to undergo pregnancy testing, despite having been advised of the possible risks of not doing so.*
6. *I confirm that I have read and fully understand the above.*

PATIENT:

PRINTED NAME _____

x SIGNATURE _____

____/____/____ DATE ____:____ am pm TIME □ Patient □ Other:

WITNESS:

PRINTED NAME _____

x SIGNATURE _____

____/____/____ DATE ____:____ am pm TIME

Documentation of physician/provider discussion with patients waiving through question #2 above (not necessary for patients attesting through question 1).

I have explained to the patient/representative the risks of proceeding with the procedure without undergoing pregnancy testing and have answered all patient/guardian questions.

PRINTED NAME _____

x SIGNATURE _____

____/____/____ DATE ____:____ am pm TIME

Revised 10/26/18