MEDICAL IMAGING OF RICHMOND

# X-Ray PREGNANCY CONSENT

Patient Name: _____ Date: _____

Date of Birth: _____ Referring Physician: _____

MUST BE COMPLETED FOR / BY ALL FEMALES OF CHILDBEARING AGE

The radiation used in X-Ray may be harmful to an unborn child. To help prevent the accidental irradiation of an unrecognized pregnancy, and in accordance with national standards, we require 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? Y or N

2. If you are not currently on birth control, have you had sexual activity since your last menstrual period that may put you at risk of pregnancy? Y or N

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 Medical Imaging of Richmond, LLC or the employees of the facility responsible for any potential harm to my unborn child or myself.

_____ _____ _____

Print name of patient or responsible party Signature of patient or responsible party Date