FREDERICK RADIOLOGY
Diagnostic Center
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X-RAY/ CT/ MRI
PREGNANCY CONSENT

Patient Name: _____ Date: _____

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/ 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? Y or N or Unsure

2.) Are you currently breastfeeding? Y or N

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 Y or N

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 Frederick Radiology & Diagnostic Center, the employees of the facility, and/ or American Radiologist Association 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