PATIENT IDENTIFICATION AREA

BRIGHAM AND WOMEN'S HOSPITAL

75 Francis Street. Boston mass. 02115

Department of Radiology

Consent for Imaging Exams (excluding Ultrasound/MRI) During Pregnancy

Dr. _____ (referring physician) would like you to have an imaging exam to check _____(indication). We have decided that an X-ray / CT (circle one) is the best available exam/test. Because you are pregnant, we would like you to understand what we know about the effects of the imaging exam/test are on your baby.

Section One: ☐ **Does Not Apply** ☐ **Applies**
You will be undergoing an X-ray / CT scan study (circle one). You and your unborn baby will be exposed to radiation. The risk to you is very small. The risk to your unborn baby is unknown. Your physician has considered the risks associated with this examination and believes it is in yours and your unborn baby's best interest to proceed. Any questions you have about the exam should be directed to your physician.

Section Two: ☐ **Does Not Apply** ☐ **Applies**
You will be given intravenous (IV) contrast during the scan. Your unborn baby will be exposed to the (IV) contrast agent. The FDA considers the safety of this agent for your baby as unproven. They recommend that the IV contrast be used only if the potential benefits outweigh the risks.

IV Contrast may be needed if;

1. The information needed from the CT/X-ray study cannot be acquired without the use of contrast or by using other imaging exams/tests
2. The information needed affects the care of you and your unborn baby during the pregnancy
3. Your physician is of the opinion that it is not a good idea to wait to get this information until after you are no longer pregnant

Additional comments (if any):

The other diagnostic imaging exams/tests available as well as the possibility of not doing the exam/test have been explained to me, and I wish to go ahead with the imaging exam.

I understand this consent information and have had the chance to have my questions answered. I agree to have the _____ exam performed.

_____ Date_____Time_____ AM/PM
Patient/Surrogate Decision Maker Signature

_____ _____
Patient Name (Print) Surrogate Decision Maker Name if applicable (Print)

_____Other
NP
PA
Signature_____ MD CID ☐☐☐☐☐ Date_____ Time_____AM/PM