

Pregnancy Release Form

It is recognized that ionizing radiation can be harmful to a fetus or that the effects of a magnetic field has been undetermined as of yet. It is the policy of University General Hospital (UGH) that women who are pregnant or suspect that they are pregnant should not have an exam that utilizes ionizing radiation or magnetic fields unless the referring physician and/or radiologist determine the exam is medically necessary. **UGH** requires confirmation of pregnancy/non-pregnancy for women of childbearing age prior to performing any radiographic procedure involving ionizing radiation or magnetic field. Childbearing age is considered to be between 10-60 years of age.

PATIENT: Please check and initial your pregnancy status:

- _____ I am not pregnant _____ (Patients Initials)
- _____ I am _____ weeks pregnant _____ (Patients Initials)
- _____ I am unsure of my pregnancy status _____ (Patients initials)

Pregnancy may be confirmed with blood/urine test at the patients' expense. I understand that the urine pregnancy test that **UGH** utilizes is not 100% accurate, and if the test is performed within 21 days of conception the results may not be accurate. If you are pregnant or suspect that you may be pregnant, your options are as follows:

UNCLEAR PREGNANCY STATUS

_____ I have decided to reschedule the exam/procedure until my pregnancy status is confirmed. **UGH** personnel will notify my physician of the delay of my exam.

_____ I am unsure of my pregnancy status and have decided to decline a pregnancy test. I have decided to have the exam with ionizing radiation and have opted to be shielded. I understand that the shield is not 100% protective against ionizing radiation, and for some procedures requiring images of the pelvis, shielding is not possible.

_____ I have had a pregnancy test and the results indicate that:

- _____ I am **not** pregnant _____ (Patients Initials)
_____ I am pregnant _____ (Patients Initials)

POSITIVE PREGNANCY STATUS

At this time I (have):

- _____ Consented to undergo the exam/procedure _____ (Patients Initials)
_____ Decline the exam/procedure _____ (Patients Initials)

By signing below, I agree that the above statements are true and hereby release **UGH** from any complications that may occur from exposure to radiation or a magnetic field and assume responsibility for my decision to undergo the procedure/exam.

Patient/Legal Representative Signature

Date/Time

University General Hospital Staff

Date/Time

Tech Only: Pt Shielded YES / NO Tech Initials _____