



**CONSENT FOR WOMEN OF CHILDBEARING AGE**

**REQUIRED FOR ALL FEMALES AGES 11-55**

Patient Name: \_\_\_\_\_ Last 4 numbers of SS#: \_\_\_\_\_

Referring Physician: \_\_\_\_\_ Next Appointment Date: \_\_\_\_\_

We sometimes ask the cooperation of our patients by asking "personal" but necessary and important questions in order to provide you quality care. The amount of radioactivity used in X-Rays, Nuclear Medicine exams, CT and P.E.T. scanning is small and the slight risk of radiation exposure to you is warranted in view of the diagnostic information to be gained; however, it is recognized that this radiation can be harmful to a fetus. The risk of radiation exposure to an unborn fetus is significant in that it may cause genetic effects. For this reason, women who are pregnant or who might be pregnant should follow through with these exams only under the advice and close monitoring of their physician or the study should be postponed until such a time that we could ensure that you are not pregnant. Baptist M&S Imaging requires confirmation of pregnancy/non-pregnancy for women of child-bearing age prior to performing each scan.

The 10 days following the onset of a menstrual period generally is considered safe for diagnostic examinations that have radiation exposure.

Please answer the following questions:

Are you pregnant, or do you think you may be pregnant? .....  YES  NO

If yes, pregnancy test results: Test Date: \_\_\_\_\_

Do you have menstrual cycles? .....  YES  NO

If yes, please answer the following questions:

a. Date when last menstrual period started: \_\_\_\_\_

b. Do you practice birth control? .....  YES  NO

c. Have you been sexually active since your last cycle? .....  YES  NO

I realize that if I am pregnant and have radiation to the abdomen, there is a possibility of injury to the fetus. I acknowledge that I understand the significant risk of radiation exposure to an unborn fetus and that to the best of my knowledge, I am not pregnant. I therefore wish to have the exam performed now.

\_\_\_\_\_  
Patient's Signature

\_\_\_\_\_  
Date