Please fill out with printed capital letters.

Name:	Mother's name:
Date of birth:	SSN:

Information and consent for pregnant patients to perform an examination using ionizing radiation

— Dear Patients,

You must complete this questionnaire & consent because you have indicated in the medical consent that you are pregnant or may be pregnant.

Ionizing radiation can be harmful to a fetus. It is the policy of Affidea that females who are pregnant or suspect (between 12-50 years) that they are pregnant should not have a procedure that uses ionizing radiation unless the referring physician and/or radiologist/ specialist doctor in nuclear medicine determine that it is medically necessary. The tests are performed in compliance with the maximum radiation protection measures.

Radiation to the embryo/fetus is minimally associated with but not limited to the following risks: increased risk of childhood cancer, congenital abnormality, mental retardation, small head size and miscarriage.

Please mark the stage of your pregnancy with an X:

☐ 1st trimester: 1-3 months

☐ 2nd trimester: 4-6 months

☐ 3rd trimester: 7-9 months

Consent form

I, the undersigned, hereby declare that I have been fully informed both in written and verbal form, especially about the nature, purpose and steps of the procedure in a way that I can understand. I have also been informed about the possible complications, benefits and risks of a missed examination, and my rights about consenting to the examinations and interventions.

I was given the opportunity to ask further questions, my questions about the procedure (if I had any) were answered to my satisfaction, and I understand what was said. I was given the opportunity to learn the name, qualification and position of the personnel directly involved in the procedure. I have no further questions and I do not need further time to think. I have been given sufficient time to make my decision and I give my consent under no duress and of sound mind.

☐ **I decided to reschedule the procedure.**

☐ **I have read and fully understand the above and I hereby give my consent to the examination using ionizing radiation.**

Signature of the patient (or legal representative) _____

If the PATIENT CANNOT MAKE A STATEMENT and/or sign on their own behalf, the reason for this

☐ Minor (under the age of 18)

☐ Vulnerable adult (diminished capacity/incapacitated)

☐ Other – please specify

_____

Full name of legal representative
(Please completed with printed letters.) _____

Date of signing the statement _____