AUSTIN RADIOLOGICAL ASSOCIATION
PREGNANCY RELEASE FORM

It is recognized that *ionizing radiation* can be harmful to a fetus and that the effects of a *magnetic field* on a fetus has been undetermined as of yet. It is the policy of Austin Radiological Association that females 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. Austin Radiological Association requires confirmation of pregnancy/non-pregnancy for females of childbearing age prior to performing a radiological exam. Childbearing age is considered to be between 10-55 years of age.

VISITORS: _____ I am not pregnant and have chosen to enter the scan/exam room with the patient _____
Visitor Initials

For the privacy and safety of our patients, visitors are not allowed in the room for some exams.

_____ _____
Visitor Signature **Date/Time**

PATIENT:

NEGATIVE PREGNANCY STATUS:

_____ I am not pregnant _____
Patient Initials

Pregnancy may be confirmed with a urine test at the patient's expense. I understand that the home urine pregnancy test that ARA currently 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 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. ARA personnel will notify my physician of the delay of my exam.

_____ I have declined a pregnancy test and have decided to proceed with my examination.

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

*_____ I am pregnant _____ *_____ I am not pregnant _____
Patient Initials Patient Initials

POSITIVE PREGNANCY STATUS:

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. The effects of a magnetic field on a fetus has been undetermined as of yet. The possible risk vs. benefit of the exam/procedure has been discussed with me. I have been given the opportunity to ask questions about the proposed imaging procedure, and its risks and alternatives. I have sufficient information to give this informed consent. The form has been explained to me, I have read it or had it read to me, and I understand its contents. At this time I have:

_____ I have read and fully understand the above and hereby give my consent to have an X-ray or MR procedure performed. I have been informed of the estimated risks to my embryo or fetus. _____
Patient Initials

_____ Declined to undergo the exam/procedure _____
Patient Initials

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

_____ _____
Patient/Guardian Signature Date/Time

_____ _____
ARA Technologist/Nurse/Medic Date/Time

Report Name: PREGRELEASE