Hackensack University Medical Center
Waiver for Imaging Studies during Pregnancy

Date:___________

Patient Name:_______________ MRN:______________

( ) MRI
( ) CT
( ) X-Ray
( ) Mammography
( ) Nuclear Medicine
( ) Special Procedures

I am__________months/weeks pregnant and I recognize that the above noted procedure does carry with it a remote possibility of injury to a fetus especially within the first trimester. It is the policy of Hackensack University Medical Center Radiology Department not to routinely perform imaging studies on women who are pregnant.

I understand that the likelihood of injury to the fetus is slight and that my physician feels that the information to be gained from this examination is important enough to my health to overlook any potential negative outcome to my pregnancy.

I certify that I have read, fully understand, and give voluntary consent to this procedure and release HUMC of any action or responsibility that may occur during my pregnancy or thereafter.

____
Signature of Patient and Date
(Legal guardian, Healthcare representative or Next of Kin).

____
Witness Signature and Date

____
Print Name and Relationship, if other than patient

____
Print Witness Name