INFORMED CONSENT
FOR IMAGING EXAMINATIONS OF PREGNANT OR POTENTIALLY PREGNANT PATIENT

You are scheduled for ________________________________________________________________

☐ The examination might slightly increase the possibility of cancer later in the child’s life, but the actual potential for a healthy life is very nearly the same as that of other children in circumstances similar to yours. The examination does not add to risks for birth defects.

☐ There have not been any reported cases of significant risk to an unborn child due to MRI.

It is the opinion of your physician that the risks of the radiation to your and your fetus are outweighed by the potential benefits that the results of this examination may provide. Any questions you have regarding this examination should be directed to the radiologist.

Radiology or referring Physician ________________________ Date ______________ Time __________

I, ________________________________________________, have read and fully understand the above and hereby give my consent to having the above mentioned procedure performed. I have been informed of the estimated risks to my embryo or fetus.

Patient/Guardian signature______________________________ Date_________________ Time__________

American College of Radiology (ACR) Practice Guideline for Pregnant or Potentially Pregnant Patients 2008