

PT Name: _____

MR#: _____

Patient Addressograph Label _____

**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

