Dartmouth-Hitchcock
Department of Radiology

Consent for
Imaging Exams during Pregnancy

NAME:

DOB: Two identifiers needed

MRN:

Your referring provider, _____ would like you to undergo a _____ (imaging exam) to evaluate _____ (indication).

We have determined this exam is medically necessary and is the best available method of evaluation. Because you are pregnant, we would like you to understand what we know about the effects of the imaging study on your embryo/fetus (hereafter referred to as child). Please note we will make every effort to minimize any and all potential risks, including using the lowest amount of radiation as reasonably possible.

The following checked items apply:

- ❑ You will be undergoing an imaging study that will not expose your child to significant radiation above what the average person is already exposed to in a day just living on Earth. The risk to your child is **negligible**.

- ❑ You will be undergoing an imaging study that will expose your child to ionizing radiation above a level that a typical person is already exposed to by living a day on Earth.

For typical radiologic examinations of the abdomen/pelvis, the dose to the child is usually well below any threshold that may induce developmental abnormalities. Radiation at higher doses (more than is anticipated during your study) has been associated with a **slightly** increased risk of:

- Miscarriage (within the first month of pregnancy)
- Congenital abnormalities (within the first trimester)
- Intellectual disability (within the second trimester)

There is a **slightly** increased risk of childhood cancer (increased by about 0.8% from the lifetime risk of cancer in an individual of 40%). The actual potential for a healthy life is very nearly the same as that of other children in circumstances similar to yours but who are not provided the benefit of this medical examination.

- ❑ You will be given iodinated intravenous contrast during the scan. The FDA considers the safety of this agent to be Category B, meaning that laboratory testing has not shown any risk to a fetus, however, studies have not been performed in humans. They recommend it be used only if the potential benefits outweigh the risks.

I am aware that the practice of medicine is not an exact science, and I acknowledge that no guarantees have been made to me regarding the outcome of this pregnancy.

By my signature below, I acknowledge that the nature, purpose, and exam as described above, expected benefits, risks, potential problems that might occur during the exam and following, the likelihood of achieving goals and outcomes, and possible alternatives, including risks and benefits, and my right to refuse this exam, and the consequences thereof, have been explained to me/us. I acknowledge and agree that my signature below indicates I have had the above information explained to me in detail and I have had an opportunity to ask questions and have them answered to my satisfaction and I have had the opportunity to discuss and advise my intent if life-threatening treatment is needed during this exam. I have read (or someone has read to me) the information in this consent form and I consent to this exam. I acknowledge that no guarantees have been made to me regarding the outcome of this pregnancy.

_____

Signature of patient or person authorized to consent on patient's behalf **Relationship**

Optional Witness _____

I have personally explained the nature of the patient's condition, why this test is needed, and the risks/benefits of the exam.

_____

Radiologist/Referring Provider Time Date

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INTERPRETER

If the interpreter is necessary and physically present, please request a signature below:

_____

Signature of person interpreting information for patient

If interpreting is done using a commercially available language line, identify the name of the interpreter and the commercial service.

_____ _____

Name of individual interpreting information for patient | Name of commercial services vendor