McLAREN FLINT
Flint, Michigan

CONSENT FOR WOMEN OF CHILDBEARING AGE

(Required for all female patients age 12-55)

Patient Name: _____ Date of Exam: _____

Prescribed Exam: _____ Radionuclide: _____ Amount: _____

Medical Record Number: _____ Encounter Number: _____

Onset of last menstrual period _____

I am declining a urine pregnancy test	Yes _____	No ____	
I am pregnant	Yes _____	No ____	Don't Know ____
I have had a hysterectomy	Yes _____	No ____	
I am currently breastfeeding an infant	Yes _____	No ____	(Nuclear Medicine only)

I recognize that if I am pregnant and have radiation to the abdomen and/or pelvis, there is a possibility of injury to the fetus. However, I understand that the likelihood of such injury is slight and that my physician feels the information to be gained from the examination is important to my health. I, therefore wish to have this x-ray examination performed now.

I have read and fully understand the above and hereby give my consent to have an X-ray procedure performed.

_____ _____
Patient/parent/guardian Date

_____ _____
Witness Date

Beta HCG Ordered **Yes (results) _____ No _____**

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PT.

MR.#/RM.

DR.