



JERSEY ADVANCED MRI

& Diagnostic Center



ACR ACCREDITED FACILITY

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PREGNANCY SCREENING & CT EXAMINATION CONSENT

For patients who are pregnant, may be pregnant, or are unsure of pregnancy status

Patient name: _____ Date of birth: _____

Date: _____ Ordering clinician: _____

Requested CT examination / body area: _____

PREGNANCY SCREENING

1. Are you currently pregnant, or is there a possibility you may be pregnant? ☐ Yes ☐ No ☐ Unsure
2. First day of your last menstrual period (if known): _____
3. Are you using contraception? ☐ Yes ☐ No ☐ Prefer not to answer
4. Are you currently trying to become pregnant? ☐ Yes ☐ No ☐ Prefer not to answer
5. Has a pregnancy test been performed for this examination? ☐ Yes ☐ No ☐ Not applicable
If yes: Date _____ Result: ☐ Positive ☐ Negative ☐ Pending

INFORMATION ABOUT CT DURING PREGNANCY

Computed tomography (CT) uses X-rays (ionizing radiation) to create detailed images. Radiation exposure to an embryo or fetus depends on the body area scanned and the examination technique. When the abdomen or pelvis is imaged, fetal exposure may occur; for examinations away from the abdomen and pelvis, fetal exposure is generally very low. Potential risks depend on the dose and stage of pregnancy and may include a small increase in future cancer risk. Most medically indicated diagnostic CT examinations do not expose a fetus to doses associated with birth defects or pregnancy loss.

Your treating clinician and imaging team should consider the medical need for the examination, whether ultrasound or MRI could answer the clinical question, and ways to minimize radiation exposure while obtaining the necessary images. Delaying a necessary examination can also carry risks. You may ask questions before deciding.

PATIENT ACKNOWLEDGMENT AND DECISION

By signing below, I confirm that I have provided pregnancy information to the best of my knowledge. I have been informed that CT uses ionizing radiation, that pregnancy-related risks and possible alternatives should be discussed with my care team, and that I have had an opportunity to ask questions. I understand that I may decline the examination and discuss the consequences of doing so with my clinician.

☐ I consent to the CT examination described above. ☐ I decline the CT examination at this time.

Patient / authorized representative signature: _____ Date/time: _____

Printed name: _____ Relationship (if representative): _____

Interpreter (if used): _____ Witness (if required): _____

CLINICAL TEAM DOCUMENTATION (complete when pregnancy is known or suspected)

☐ Indication, pregnancy status, risks/benefits and alternatives reviewed with patient

Clinician name / signature: _____ Date/time: _____

This form supplements, but does not replace, facility policy, clinical assessment, and any procedure-specific consent.