Providence Hospital
of North Houston

Patient Sticker

Pregnancy Release Form

It is recognized that ionizing radiation can be harmful to a fetus or that the effects of a magnetic field has been undetermined as of yet. It is the policy of Providence Hospital of North Houston that women who are pregnant or suspect that they are pregnant should not have an exam that utilizes ionizing radiation or magnetic fields unless the referring physician and/or radiologist determine the exam are medically necessary. Providence Hospital of North Houston requires confirmation of pregnancy/non pregnancy for women of childbearing age prior to performing any radiographic procedure involving ionizing radiation or magnetic field. Childbearing age is considered to be between 10-60 years of age.

PATIENT: Please check and initial your pregnancy status:

- _____I am not pregnant _____(Patients Initials)
- _____I am _____weeks pregnant _____(Patients Initials)
- _____I am unsure of my pregnancy status _____(Patients Initials)

Pregnancy may be confirmed with blood/urine test at the patients' expense. I understand that the urine pregnancy test that Providence Hospital of North Houston utilizes is not 100% accurate, and if the test is performed within 21 days of conception the results may not be accurate. **If you are pregnant or suspect that you may be pregnant, your options are as follows:**

UNCLEAR PREGNANCY STATUS:

_____I have decided to reschedule the exam/procedure until my pregnancy status is confirmed Providence Hospital of North Houston personnel will notify my physician of the delay of my exam.

_____I am unsure of my pregnancy status and have decided to decline a pregnancy test. I have decided to have the exam with ionizing radiation and have opted to be shielded. I understand that the shield is not 100% protective against ionizing radiation, and for some procedures requiring images of the pelvis, shielding is not possible.

_____I have had a pregnancy test and the results indicate

____I am not pregnant_____(Patients Initials)
____I am pregnant_____(Patients Initials)

POSITIVE PREGNACY STATUS:

At this time **I am pregnant** and I (have):

_____Consented to undergo the exam/procedure_____ (Patients Initials)
_____Decline the exam/procedure _____ (Patients Initials)

By Signing below, I agree that the above statements are true and hereby release Providence Hospital of North Houston from any complications that may occur from exposure to radiation or a magnetic field and assume responsibility for my decision to undergo the procedure/exam.

_____ _____
Patient/Legal Representative Signature Date/Time

_____ _____
Providence Hospital Staff Date/Time

Tech Only: Pt Shielded: YES /NO Tech Initials _____