Hackensack Meridian *Health*
Mountainside Medical Center

Women's Breast Center

PREGNANCY EVALUATION AND CONSENT FORM

Name: _____

In order to fully evaluate your medical condition your doctor has requested that the following x-ray examination(s) be performed

_____

_____

Last menstrual period _____

Are you now, or is it possible that you might be pregnant? **YES** **NO**

IF YES, how many weeks / months: _____

Have you breast fed in the past 3 months **YES** **NO**

Your doctor has that the requested examination (s) are necessary in determining your medical diagnosis .
It is his medical opinion that the benefits of the examination (s) are greater than the possible risk.
If the examination will allow, precautions may be taken by shielding the abdomen.

1. To the best of my knowledge, **I am NOT pregnant**

Signature Date Witness

2. **I may be pregnant at ths time**. I have been informed of the possible effects of radiation to a developing fetus and have consented to the x-ray examination(s) ordered by my physician.

Signature Date Witness

3. **I may be pregnant at this time. I do not wish to have an x-ray examination at this time.**

Signature Date Witness

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