Houston MRI & Diagnostic Imaging

Facility:	Referring:
MRN:	Radiologist:
DOS:	Delivery:

X-RAY CONSENT FORM

CONSENT FOR X-RAY EXAMINATIONS

Patient: _____ Minor ☐Yes ☐No

Referring Doctor:_____

Examination to be performed:

_____

When is your next follow up appointment with your doctor?

_____

I consent to these diagnostic x-ray procedure(s) my referring doctor may consider necessary or advisable in the course of my health care. I understand that the above listed diagnostic x-ray procedure(s) have been ordered by my referring doctor and are to be performed at Houston MRI by or under the supervision of a radiologist and/or radiological technologist. I understand the nature and purposes of these procedure(s) and the risks involved, and the possible consequences of not consenting to the procedure(s).

_____ Date: _____/_____/_____
Patient / Guardian Signature

_____ _____
Witness Relationship

FEMALE PATIENTS ONLY

Some X-Ray and CT examinations may expose the uterus. In order to avoid unnecessary fetal exposure in the event of a pregnancy, the 10 days immediately following onset of menstrual period are generally considered safest for x-ray examinations.

Onset of last menstrual period. Date: ____/____/____ Today's Date: ____/____/_____

I am postmenopausal	☐Yes	☐No	☐Don't know
I am pregnant	☐Yes	☐No	☐Don't know
I have had a hysterectomy	☐Yes	☐No	☐Don't know
I use an IUD	☐Yes	☐No	☐Don't know

I recognize that if I am pregnant and have radiation, 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 that the information to be gained from this examination is important to my health. I therefore wish to have this x-ray examination performed now.

_____ Date: _____/_____/_____
Patient / Guardian Signature

_____ _____
Witness Relationship