



Beth Israel Deaconess Medical Center

MRI CONSENT FORM FOR PREGNANT PATIENTS Radiology Department

PATIENT'S NAME
MED. REC. #
DOB
<i>Patient Identification</i>

Dr. _____ has discussed MRI with me and its use for the purpose of detecting abnormalities.

I understand that the exam will be performed in an MRI system that uses radio waves and magnets to obtain an image.

Benefits and Alternatives to Treatment: My doctor talked with me about the benefits I may expect from this imaging exam but made no guarantees or promises concerning the results of the exam. My doctor also talked about what could happen if I do not have this procedure, and explained other options for my care.

I understand the following:

- The physician who ordered the exam will explain all results to me. Any available options or treatments will be outlined and provided. The decision on how to proceed is entirely mine.
- The American College of Radiology considers the use of MRI risk free during pregnancy.

Trainees & Observers: Beth Israel Deaconess Medical Center is a teaching facility. This means that health care trainees such as resident physicians and students may be involved in or observe my care. All trainees are supervised during the MRI exam. I have read and understood the content of this form. I have had the opportunity to discuss this with my physician and have had my questions answered.

I consent to the MRI and medical care.

X _____ or X _____ X ____/____/____
Patient's Signature Person authorized to sign for patient and relationship to patient Date

I have explained the above statements, and answered all the patient's questions.

X _____ M.D. X _____ M. D. X ____/____/____
Physician Print Name Date