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**Pregnancy Release and Consent Form**

Date: \_\_\_\_\_

Patient Name: \_\_\_\_\_ Patient Account #: \_\_\_\_\_

Patient DOB: \_\_\_\_\_

Please answer the following questions:

Are you pregnant or any chance you may be: \_\_\_\_\_

Date of the start of your last period: \_\_\_\_\_

What type of birth control do you use:

\_\_\_\_\_ Birth control pills                      \_\_\_\_\_ Depo Provera  
\_\_\_\_\_ IUD                                              \_\_\_\_\_ Patch

Are you trying to get pregnant?              Yes              No

Any surgeries? List types: \_\_\_\_\_

Please initial the line and check the box for the following that apply.

\_\_\_\_\_ I acknowledge that NWDC Diagnostic Imaging may require that I have a urine and/or blood pregnancy test before I have any imaging procedures since I am 50 years of age or younger and have not had a Tubal Ligation or a Hysterectomy.

\_\_\_\_\_ I do not feel it is necessary for me to take a pregnancy test before I have any imaging procedures. I am aware of the potential medical risks due to exposure of radiation to myself and if I were pregnant, my unborn child.

\_\_\_\_\_ I will not hold NWDC Diagnostic Imaging, or any of the doctors or staff liable if I have an imaging procedure(s) and find out that I am pregnant afterwards.

Your signature indicates that you have read and understand the above and accept all responsibility associated with exposure to your self or your unborn child and have accurately answered the above statements.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Technologist/Witness Signature: \_\_\_\_\_ Date: \_\_\_\_\_