OUR MED
OUR FAMILY CARING FOR YOURS

X-RAY CONSENT FORM

Patient: _____ **Date:** _____

During your examination, the doctor may feel that x-rays will be needed to diagnose your condition. We would like to make you aware that x-rays may be required, in order to administer treatment. In order to perform x-rays on any patient our office requires the patients consent for such tests to be performed.

Please choose one:

_____I understand that my doctor may need x-rays in order to diagnose my condition and I give permission of all needed diagnostic tests.

_____I understand that my condition may require my doctor to take x-rays to further diagnose my symptoms, but I choose not to have any x-rays at this time and release my doctor of all liabilities.

Signature: _____ **Date:** _____

___ I understand that if I am pregnant and have x-rays taken which expose my lower torso to radiation, it is possible to injure the fetus.

___ I have been advised that the ten (10) days following onset of a menstrual period are generally considered to be safe for x-ray exam.

___ With those factors in mind, I am advising my doctor that:

(Please circle your choice)

I am pregnant	**Yes**	**No**	**Don't Know**
I could be pregnant	**Yes**	**No**	**Don't Know**
I have an IUD	**Yes**	**No**	
I have had a tubal ligation	**Yes**	**No**	
I have had a hysterectomy	**Yes**	**No**	
I have irregular menstrual periods	**Yes**	**No**	
I have begun menopause	**Yes**	**No**	

With full understanding of the above, and believing that I am not currently at risk, I wish to have an x-ray examination performed today if requested by my doctor.

Signature: _____ **Date:** _____