



Diagnostic Radiology OF HOUSTON

CONSENT FOR X-RAY EXAMINATIONS

Patient: _____ Minor Yes No

Referring Doctor: _____

Examination to be performed: _____

I consent to those diagnostic x-rays 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 procedures have been ordered by my referring doctor and are to be performed at Diagnostic Radiology of Houston by or under the supervision of our 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 procedures.

Patient / Guardian Signature: _____ Date: _____

Witness: _____ Relationship _____

FEMALE PATIENTS ONLY

Some X-Ray & 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.

Patient / Guardian Signature _____

Witness _____ Relationship: _____