Informed Consent for NON-INVASIVE Procedure(s) and / or Treatment *CP 2.10*

Date _____ **Time** _____

I, the undersigned, consent to the following procedure(s); **MR Imaging During Pregnancy** _____

_____

_____

to be performed by Dr. _____ and his / her associates and assistants (including resident physicians), with knowledge that the attending physician will have primary responsibility for my care specific to the stated procedure. Dr. _____ has explained to me the nature and purpose of each procedure(s) as well as the substantial risks and possible complications involved, the benefits and the medically reasonable alternative methods of treatment.

The **SUBSTANTIAL RISKS** include but are not limited to: Although no risks from MRI have been proven, the United States Food and Drug Administration has not approved MRI imaging in pregnant women. The procedure, therefore, is reserved for emergency situtations. Any potential risks to the fetus due to changing magnetic fields and radiofrequency pulses, such as behavioral changes, cellular changes, or possible induction of cancer, are believed to be greater during the first trimester. Numerous fetuses have undergone MRI during the second and third trimesters without any reported abnormalities at birth up to four years of development, although long-term studies have not been performed. MRI is believed to be safer than CT or other forms of standard radiology procedures in which radiation and intravenous contrast material are known to be deleterious to the fetus. Because of the limited number of avenues open to study patients with problems similar to yours, your physician is of the opinion that MRI appears to represent a reasonable alternative. Again, it is stressed that the long-term effects are not completely known.

The **POTENTIAL BENEFIT(S)** include but are not limited to: Ability to diagnose the cause of your symptoms and to initiate appropriate treatment in a timely manner. _____

The **MEDICALLY REASONABLE ALTERNATIVE(s)** options are: Delay of MRI exam to later time in the pregnancy or following delivery. _____

- **I understand that the information I have received, about risks is not exhaustive and there may be other, more remote risks.**
- **I have had the opportunity to ask questions regarding the proposed procedure(s) and all my questions have been answered to my satisfaction.**
- **I have read or have had read to me, this Procedure(s) Informed Consent form.**
- **I have had explained to me and I understand the potential benefits and drawbacks, potential problems related to recuperation, the likelihood of success, the possible results of non-treatment, and any medically reasonable alternatives.**
- **I have received no guarantees from anyone regarding the results that may be obtained.**
- **I know the relationship, if any, of my physician or other practitioner, to any teaching facility involved in my care.**

Shands HealthCare

Facility:

Shands at UF

please print facility name

This form provided by Shands as a courtesy to physicians and their patients.

AC0001

If printed electronically, pages 1 & 2 must be stapled.

Patient Name: Patient Identification #:

My initials below indicate whether observers may be present during my procedure, in accordance with my physicians' approval and hospital policy.

_____ **I give** permission to allow observers in the room during my procedure.

_____ **I do not give** permission to allow observers in the room during my procedure.

CONSENT

I do hereby consent to the above described procedure(s).
Date _____

Patient Signature _____ Patient Printed Name _____

Witness Signature _____ Witness Printed Name _____

SIGNATURES FOR CONSENT WHEN GIVEN BY REPRESENTATIVE OF PATIENT

If patient is unable to consent, complete the following:
☐ Patient is a minor, or
☐ Patient is unable to consent because: _____

Date _____

Patient's Name _____

Representative's Signature _____

Representative's Printed Name _____ Relationship to Patient _____

Witness Signature _____ Witness Printed Name _____

SIGNATURE OF PHYSICIAN WHO OBTAINED CONSENT

I certify that the procedure(s) described above, including the substantial risks, benefits, possible complications, anticipated results, alternative treatment options (including non-treatment) and their attendant risks and benefits, the likelihood of success and the possible problems related to recuperation, were explained by me to the patient or his / her legal representative.

Date _____ **Time** _____

☐ Consent obtained by telephone.
☐ Consent obtained with use of interpreter.
Name of interpreter _____

Signature of Physician Who Obtained Consent _____

Physician Identification Number _____