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 situations. 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 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

**NON-INVASIVE Procedure(s) and / or Treatment** MR Imaging During Pregnancy

**Informed Consent** (page 1 of 2)
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 ___________________________