ORLANDO HEALTH® | Imaging Centers

LINE UP PATIENT I.D. LABEL HERE

DIAGNOSTIC IMAGING FOR WOMEN OF CHILD BEARING AGE
(STATE AGE RANGE_____) / FETAL PROTECTION

ALTAMONTE / DOWNTOWN ORLANDO / SPRING LAKE / OCOEE / SANFORD

Date: _____

X-rays, CT Scans, Mammograms, and IVPs (IntraVenous Pylogram) may be harmful and pose a risk to an unborn child. Please complete the following:

Patient's Name: _____
(Print)

Date of Birth: _____/_____/_____

I acknowledge the potential risk associated with the above procedures to an unborn child and I declare that I am <u>not</u> pregnant and wish to proceed with diagnostic study.

❑ I do not wish to proceed with the diagnostic study at this time.

Patient's Signature: _____ Date: _____ Time:_____

INTERPRETER ONLY

(Please Print)

Name: _____ Agency: _____

Telephone:_____ Language: _____