Informed Consent for Pregnancy Testing

**Pregnancy Testing**: All female patients presenting at Ivinson Memorial Hospital (the “Hospital”) of childbearing age shall receive a pregnancy screening and a pregnancy test if applicable. Adult patients may make the informed decision to refuse a pregnancy test screening by written indication below.

I request and consent to a urine or serum pregnancy test, to be performed by the Hospital as part of the Hospital’s routine pre-treatment lab work. I consent because of the possible risks of anesthesia, certain medications, and procedures to an unborn fetus, including birth defects and miscarriage. I understand pregnancy tests are generally accurate, but no pregnancy test is 100% reliable, and there is a possibility the pregnancy screening test administered will not detect an early pregnancy. The test may also indicate a false positive result.

Signature of Patient ___________________________________________________ Date/Time: ______________________________

The patient is unable to sign because _____________________________ and I therefore sign for the patient.

Signature ______________________________ Relationship to the patient____________________ Date/Time: __________________

Witness Signature: ____________________________________________ Date/Time: ___________________________

☐  **Order for Urine/Serum (circle) qualitative pregnancy test prior to procedure**

**Physician Signature:** __________________________________________ Date/Time: _____________________________

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**Option for Adults to Refuse Pregnancy Testing**

I am 18 years of age or older and hereby refuse a pregnancy test and voluntarily assume the risk of injury and damage to me and my unborn child if I am pregnant. (Some procedures require a pregnancy test and refusal may not be an option). I understand the procedure/treatment I am about to undergo in the Hospital presents risk to an unborn fetus because of the risks of anesthesia, certain medications, and procedures, including, but not limited to, birth defects and miscarriage to an unborn fetus. I voluntarily assume the risk of injury and damage to me and my unborn child if I am pregnant.

Signature of Patient ___________________________________________________ Date/Time: ______________________________

The patient is unable to sign because _____________________________ and I therefore sign for the patient.

Signature ______________________________ Relationship to the patient____________________ Date/Time: __________________

Witness Signature: ____________________________________________ Date/Time: ___________________________

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**Informed Consent to Undergo Procedure/Treatment after Notice of Positive Pregnancy Test**

If the test indicates a positive result, I understand the procedure/treatment I will undergo in the Hospital presents risk to an unborn fetus because of the risks of anesthesia, certain medications, and procedures, including, but not limited to, birth defects and miscarriage to an unborn fetus. I voluntarily assume the risk of injury and damage to me and my unborn child if I am pregnant.

Signature of Patient ___________________________________________________ Date/Time: ______________________________

The patient is unable to sign because _____________________________ and I therefore sign for the patient.

Signature ______________________________ Relationship to the patient____________________ Date/Time: __________________

Witness Signature: ____________________________________________ Date/Time: ___________________________