MEDICAL RECORD - SUPPLEMENTAL MEDICAL DATA

For use of this form, see requiring document. Form is not valid without Requiring Document, Issuance Date, Local Form Number, and Edition Date.

REQUIRING DOCUMENT *(Title and Number)*	ISSUANCE DATE
LOCAL FORM TITLE *(Optional)*	

RELEASE FORM FOR X-RAY EXAMINATION INVOLVING PREGNANT FEMALES

I have examined the below named patient and feel that the X-ray examination that I requested is necessary for complete medical treatment and diagnosis. I am aware that the patient is approximately ( ) weeks pregnant, and have explained to the patient the possibility of radiation damage to the fetus.

DOCTOR'S PRINTED NAME	DOCTOR'S SIGNATURE	DATE

I have been informed by the doctor of any effect this X-ray examination may have on my unborn child, and agree to have this examination.

PATIENT'S PRINTED NAME	PATIENT'S SIGNATURE	DATE

****THIS DOCUMENT MUST BE FILED IN THE PATIENT'S JACKET WITH THE EXAM FILM.****

PRACTITIONER'S NAME	PRACTITIONER'S SIGNATURE	DATE
PATIENT'S IDENTIFICATION: *(For typed or written entries, give: Name - last, first, middle; SSN; Sex; Date of Birth; Rank/Grade.)*	HOSPITAL OR MEDICAL FACILITY	STATUS
	DEPARTMENT / SERVICE	RECORDS MAINTAINED AT
	SPONSOR'S NAME	SSN
	RELATIONSHIP TO SPONSOR	