**Mount Sinai**

**Mount Sinai Health System**
**New York, NY**

# REFUSAL OF PREGNANCY TESTING AND RELEASE

1. In anticipation of proposed procedure/surgery/treatment/anesthesia,

   _____ (Attending Physician/Privileged Provider) has advised that I undergo pregnancy testing.

2. I am not currently pregnant to the best of my knowledge.

3. I understand the nature and purpose of the proposed pregnancy testing. I have been informed that there may be risks and consequences to an unborn child or to me of not proceeding with the testing, including but not limited to possible miscarriage, premature delivery, damage to the fetus, or medical complications of the procedure or anesthetic that would adversely affect me, the pregnancy, or the unborn child.

4. I hereby release Mount Sinai Health System and its employees, students, medical staff, and trustees from any liability for ill effects that may result to me or to an unborn child from failure to undergo pregnancy testing.

5. I have had the opportunity to ask questions about the testing, and all of my questions have been answered to my satisfaction.

6. I choose not to undergo pregnancy testing, despite having been advised of the possible risks of not doing so.

7. I confirm that I have read and fully understand the above and that all blank spaces have been completed prior to my signing.

**Patient\*, Guardian, or Representative\*\***

| _____ | _____ | _____ | _____ | _____ |
|---|---|---|---|---|
| Print name | Signature | Date | Time | Relationship or "self" |

**Signature Witness**

| _____ | _____ | _____ | _____ |
|---|---|---|---|
| Print name | Signature | Date | Time |

I have explained to the patient/representative the risks of proceeding with the procedure/surgery/treatment/anesthesia without undergoing pregnancy testing, and have answered all of the patient/legally authorized representative's questions.

| _____ | _____ | _____ | _____ |
|---|---|---|---|
| Print name | Attending Physician/Privileged Provider Signature | Date | Time |

\* The signature of the patient must be obtained unless the patient is under the age of 18 or incompetent.

\*\*Throughout this document, the term "representative" refers to a legally authorized representative (guardian, proxy, or surrogate under the Family Health Care Decisions Act).

**NOTE: THIS DOCUMENT MUST BE MADE PART OF THE PATIENT'S MEDICAL RECORD.**

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