Rejustification Form (Adult)

Patient Name			
DOB	___/___/_____	Procedure	
MRN		Date	___/___/_____

1. To be completed by the Referrer/Practitioner if the patient is pregnant or pregnancy <u>cannot</u> be ruled out			
This procedure has been deemed clinically urgent and justified			
Signature:		MCRN	

2. To be completed by the Patient if she is pregnant or pregnancy <u>cannot</u> be ruled out	
The benefits and risks associated with this procedure have been explained to me and I consent to proceed	
Signature:	