



Rejustification Form (Adult)

Patient Name						
DOB	/	Procedure				
MRN		Date	/			
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:						

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