



**Covenant HealthCare**  
1447 North Harrison  
Saginaw, MI 48602

**CONSENT/ON-BODY EXTERNAL MEDICATION/  
MONITORING DEVICE WAIVER**

PF03220 (R 10/23)

PATIENT I.D.

**I hereby acknowledge Covenant HealthCare recommends that on-body external medication and/or monitoring devices are removed before imaging (CT, X-ray, Fluoroscopy). Removal of the device is for the safety of the patient.**

Types of risk/injury may occur when device is exposed to x-ray radiation. These risks may include but may not be limited to:

- Device damage/electronic interference to affect the function and operation of the device.
- Personal injury
- Incorrect glucose readings
- Incorrect medication administration
- Experience an interruption in monitoring or medication administration
- Require additional imaging due to the location of your device
- Artifacts on imaging exams that may limit the diagnostic quality or obscure anatomy on images resulting in a non-diagnostic or a limited study.

**I have been advised of the risk of refusal to remove on-body external medication and/or monitoring devices during imaging exam and wish to proceed with my imaging test. (CT, X-ray, Fluoroscopy) I am aware of the potential risks and consequences related to leaving device in place and am assuming these risks by not removing it. Any cost incurred related to repairing or replacing my on-body external device, as a result of my refusal to remove the device, is my responsibility. I have had the opportunity to ask questions related to these risks.**

Patients name: \_\_\_\_\_ Date: \_\_\_\_\_

Patients signature: \_\_\_\_\_ Date: \_\_\_\_\_

Witness: \_\_\_\_\_ Date: \_\_\_\_\_