Touchstone
MEDICAL IMAGING

RADIOLOGICAL PREGNANCY SCREENING
CHILDBEARING AGE FEMALES

This form must be completed for/by all female patients who have menstruated and could possibly be or become pregnant. Female patients who are pregnant or suspect that they may be pregnant should not have an exam that utilizes ionizing radiation unless the ordering physician determines the exam is medically necessary and the patient agrees to the exam after having had the risks, benefits, and alternatives explained. When possible, confirmation of pregnancy/non-pregnancy is important prior to performing an ionizing radiological exam. Although most standard ionizing radiological procedures cause low, non-harmful levels of radiation exposure to a fetus, more specialized procedures that utilize higher radiation doses may pose an increased health risk to a fetus, depending on the type of procedure, location on the female's body (e.g., pelvis, abdomen), radiation dose, and stage of pregnancy.

Print Patient Name: _____
FIRST M.I. LAST

Date of Birth: _____/_____/_____ Age: _____
Month Day Year

Start Date of Last Menstrual Cycle: _____ End Date of Menstrual Cycle: _____ □ Unknown

Yes	No	Maybe	Are you pregnant?
Yes	No		Are you currently breast feeding?
Yes	No		Have you had a medically administered pregnancy test in the past 72 hours?
Yes	No		Have you had a tubal ligation? If yes, Date: _____
Yes	No		Have you had a hysterectomy?
Yes	No		Are you currently in menopause?
Yes	No		Have you completed menopause and not had a period in the last 2 years?
Yes	No		Are you using a form of birth control or had a procedure that completely stops your periods?

I have read and understand the above questions and attest the above information is correct.

_____ _____ _____
Signature of Patient/Legal Representative Print Name of Patient/Legal Representative Date

_____ _____
Technologist Reviewing Form Date

For Internal Use:

Pregnancy testing required: □ Yes □ No Verbal consent to test: □ Yes □ No

Consent provided by: □ Patient □ Guardian Testing Technologist: _____

Test Date: _____ **Results:** □ Negative □ Positive Radiologist Consulted: □ Yes □ No

Source of Results: □ TMI Facility □ Dr Office □ Other _____

Referring Physician Notified: □Via Fax □Via Phone □Not applicable

Notes: _____