

**Form A:**  
**Pregnancy Status Check for the diagnostic and therapeutic use of radiation**

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Your Doctor/Healthcare professional has requested you undergo a procedure/investigation that requires an exposure to ionising radiation. It is our professional duty and legal responsibility to determine whether someone having this type of procedure could be pregnant before deciding whether to go ahead.

Please note we may not be able to continue today if we are unable to confirm your pregnancy status.

**As you are aged between 16 and 55 years old, please answer the following questions.**

**1. Which sex were you assigned at birth?**

- Male ☐ Go to patient signature  
Female ☐ Please got to question 2  
Other ☐ Please got to question 2

**2. Are you or might you be pregnant?**

- No ☐ Go to question 3  
Yes ☐ How many weeks pregnant are you? \_\_\_\_\_  
Go to question 3  
Unsure ☐ Are you using any form of contraception? **Yes / No**  
First day of your last menstrual period? \_\_\_\_\_  
Is your menstrual period overdue? **Yes / No / Unsure**  
Go to question 3

**3. Nuclear Medicine patients only – all other patients go straight to patient signature**

**Are you breastfeeding?**

- No ☐ Go to patient signature  
Yes ☐ Have you received the appropriate advice sheet? **Yes / No**  
Go to patient signature

Patient to sign

**I have confirmed my pregnancy status and consent to the exposure**

Signature:	Date:
Print Name:	

Staff to complete

PID/NHS number:		Date:
Staff Signature:	Print Name:	
Staff to complete (if applicable)		
Pregnancy HCG test results	Batch No.	Date:
Positive <input type="checkbox"/> Negative <input type="checkbox"/>	Staff signature:	

**Form B:**

**Justification of diagnostic radiation examination, on a patient who is or may be pregnant.**

**Operator to complete**

Investigation requested:

Date requested:

Patient Name:

Date of birth:

PID/NHS number:

**IR(ME)R PRACTITIONER (consultant radiologist or cardiologist)**

I confirm that acting as an IR(ME)R practitioner I have reviewed the justification and risk alongside the clinical history and clinical question for the above requested investigation using ionising radiation on the above named patient, who may be / is pregnant. I confirm that in my opinion the test is justified/low risk and should be performed at this time.

**Signature of IR(ME)R Practitioner:**

**Date:**

**Print name of IR(ME)R Practitioner:**

**Position:**

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**In the event of remote IR(ME)R Practitioner justification:**

Operator needs to complete the following prior to exposure

**IR(ME)R Practitioner Name:**

**IR(ME)R Practitioner position:**

I confirm justification and authorisation has taken place by the IR(ME)R Practitioner in relation to the exposure of ionising radiation and verbal agreement to proceed has been obtained

**Signature of IR(ME)R Operator:**

**Date:**

**Time:**