Hackensack Meridian *Health*
JFK Medical Center

ADVANCED MEDICAL IMAGING

Pregnancy Questionnaire

It is the policy of this facility to screen all female patients of child bearing age and who are sexually active for the possibility of pregnancy prior to performing any procedure that utilizes radiation.

Is there any possibility of pregnancy? ○ **Yes** ○ **No**

When is the 1st date of your last menstrual period? Date: _____/_____/_____

☐ Post Menopausal ☐ Post Hysterectomy ☐ Post Tubal Ligation

Please read the following before signing:

If an exam which utilizes radiation is performed in the second half of the menstrual cycle in women who are sexually active, there is a chance of radiation exposure to a developing fetus. There is a small chance that radiation from diagnostic procedures may have adverse effects to a developing fetus. If there is a possibility you could be pregnant, you may wish to reschedule your examination until after your menstruation has commenced.

By signing this form, you release this facility, the technologists performing the exam, the radiologist, and any of the staff members from any liability resulting from the radiation exposure. I understand the risks involved and still wish to have my procedure performed.

Patient Signature: _____ **Date:** _____/_____/_____

Print Patient Name:_____

Radiologist Signature: _____ **Date:** _____/_____/_____

Print Radiologist Name:_____

FILL OUT THE SECTION BELOW ONLY IF YOU ARE PREGNANT

I am or may be pregnant, but my clinical condition warrants the study. I understand the risks involved with having a diagnostic test. The risks and alternatives have been explained to me by:

Radiologist Signature: _____ **Date:** _____/_____/_____

Print Radiologist Name:_____

Patient Signature: _____ **Date:** _____/_____/_____

Print Patient Name:_____