

**PATIENT INFORMATION SHEET  
FEMALES SCHEDULED FOR DIAGNOSTIC RADIOLOGY PROCEDURES**

It is the policy of Radiology Associates of Tarrant County, PA. to exercise extreme caution in the event that a female patient between the ages of 12 and 50 is scheduled for a diagnostic imaging procedure that utilizes ionizing radiation. The effects of ionizing radiation on a fetus are potentially harmful and thoughtful consideration must be given to a female patient whose doctor has requested such a procedure (CT Scan, radiographic plain films, nuclear medicine and fluoroscopy).

Please take a moment and answer the following questions so that we might serve you and your physician in a thorough and safe manner.

Patient Name: \_\_\_\_\_

- 1) Are you between the ages of 12 and 50? YES\_\_\_\_ NO\_\_\_\_
- 2) Have you undergone a hysterectomy? YES\_\_\_\_ NO\_\_\_\_

(If you answered YES to #2, please skip the remaining questions and sign at the bottom)

- 3) Please state the approximate date of your last menstrual period: \_\_\_\_\_
- 4) Is there any possibility that you might be pregnant? YES\_\_\_\_ NO\_\_\_\_
- 5) If you have children, are you currently breast-feeding? YES\_\_\_\_ NO\_\_\_\_

**UNCLEAR PREGNANCY STATUS  
(Please initial the appropriate box and sign at the bottom)**

\_\_\_\_\_ I have decided to reschedule the imaging procedure until after my pregnancy status is confirmed. RATC personnel will notify my physician of the delay in my scheduled procedure.

\_\_\_\_\_ I have had a **blood** pregnancy test and the results indicate that I am:  
\_\_\_\_\_pregnant  
\_\_\_\_\_not pregnant

By signing below, I agree that the above statements are true and hereby release Radiology Associates of Tarrant County, PA. from any complications that may arise from exposure to ionizing radiation and assume responsibility for my decision to undergo the procedure.

\_\_\_\_\_  
Patient/Legal Representative Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed Name

\_\_\_\_\_  
Witness