BaylorScott&White
DALLAS DIAGNOSTIC ASSOCIATION
PLANO
A member of HealthTexas Provider Network

RADIOLOGY SCREENING CHILDBEARING AGE FEMALES

This form must be completed for/by all female patients who have menstruated and could possibly be or become pregnant. Although most standard radiology procedures that utilize higher radiation doses may pose an increased health risk to a fetus, depending upon the type of procedure, location on the female's body (e.g. pelvis, abdomen), radiation dose, and stage of pregnancy. The following information will help your health care provider assess and discuss with you the risks, benefits, and alternatives of performing or postponing the radiology procedure that has been ordered by your physician or whether a different or limited radiology procedure is available. This form will be retained with your medical records.

The information provided by you will be used or disclosed only in accordance with federal or state law.

Name:_____
LAST FIRST MIDDLE

Date of Birth: _____ / _____ / _____ Age: _____ MRN _____

Date of Last Menstrual Cycle : _____

1. Are you pregnant? ☐ Yes ☐ No ☐ Maybe

2. Could you be pregnant? ☐ Yes ☐ No ☐ Maybe

3. Are you currently breast feeding? ☐ Yes ☐ No ☐ Maybe

4. Do you have history of tubal ligation, and/or a hysterectomy and/or menopause? ☐Yes ☐No

I have read and understood the above information and the above information is correct.

_____ _____ _____
Signature Patient/ Legal Representative Printed Name Patient/Legal Representative Date