



**Pregnancy Waiver Form – General Radiation Risk**  
**(for women 12-50 years of age)**

As a routine part of our practice, all women of childbearing age are asked about their pregnancy status and last menstrual period. We ask that you be truthful in answering these questions as our goal is to provide the safest and highest quality of medical care. There are risks with radiation exposure in pregnancy, therefore we ask you to sign a pregnancy waiver (see below). If unsure, a urine pregnancy test is available to you.

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

Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_

Exam Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

1<sup>st</sup> Day of LMP: \_\_\_\_/\_\_\_\_/\_\_\_\_

**Verification of Non-Pregnancy**

One of the following is required before any examination involving ionizing radiation is performed:

- |   |  |
|---|--|
| <input type="checkbox"/> Within 10 Days of Last Menstrual Period                          | <input type="checkbox"/> Abstinence                      |
| <input type="checkbox"/> Hysterectomy / Tubal Ligation / Partner Vasectomy                | <input type="checkbox"/> Post Menopause                  |
| <input type="checkbox"/> Contraceptives (IUD/OCP/Depo/other)                              | <input type="checkbox"/> Negative Pregnancy Test:        |
| <input type="checkbox"/> Have Not Yet Started Periods                                     | - Urine or Serum   |
| <input type="checkbox"/> Other: _____   | - Date _____   |
| <input type="checkbox"/> NUCLEAR MEDICINE PATIENTS ONLY – are you currently breastfeeding | <input type="checkbox"/> Yes <input type="checkbox"/> No |

I, (patient) \_\_\_\_\_ certify that I am not pregnant and have been fully informed of the risks. If the chance of pregnancy is in question, I have been offered the opportunity to take a pregnancy test. I hereby release CORA/CMI of any liability if I am pregnant at the time of this examination.

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Witness Signature

\_\_\_\_\_  
Date