**Appendix 2**

**Form A: Inclusive Pregnancy form 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 11 and 55 years old, please answer the following questions.**

1. Which sex were you assigned at birth? MALE / FEMALE / OTHER (please circle)

If you have answered **Male** please move onto patient signature below. If you have answered **other** and have a potential of pregnancyplease discuss with the healthcare professional looking after you today.

**Only answer the following if you have answered Female or Other with a potential of pregnancy**

1. Have your menstrual periods begun? YES/NO
2. Are you or might you be pregnant? YES / POSSIBLY / NO (please circle)
3. If YES you are pregnant how many weeks pregnant are you? ……………………..

If NO please move onto patient signature, if POSSIBLY please continue to question 5.

1. When was the date of the first day of your last menstrual period? ………………………..
2. Is your menstrual period over due? YES / NO / UNSURE
3. Are you using any form of contraception? YES / NO

Patient Signature Date

Staff Signature Date

|  |
| --- |
| Staff to complete PID/NHS number: Date |
| Radionuclide therapy only (staff to complete)Pregnancy HCG test results Batch No. Date Positive Negative Staff signature  |