DOCUMENTATION OF PREGNANCY STATUS

Women of child-bearing age (12 - 60 years inclusive).

Patient Name ______________________________ **DOB** ______________

Are you pregnant? ☐ **Yes** ☐ **Maybe** ☐ **No**

Are you breast feeding? ☐ **Yes** ☐ **No**

If there have been more than 10 days has passed since the first day of your last menstrual period please select from the following choices as to why you would not be pregnant.

- ☐ **Hysterectomy**
- ☐ **Tubal Ligation**
- ☐ **Menopause**
- ☐ **Negative Serum Pregnancy test**
- ☐ **Birth Control pills taken daily with out missing any**
- ☐ **Other form of birth control:** ______________
- ☐ **Other:** ______________

______________________________ ______________
X Signature of patient **Date**

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ACTION TAKEN IF VERIFICATION NOT POSSIBLE (Check all that apply)

- ☐ **Serum Pregnancy test Ordered; results:** ☐ **Negative** ☐ **Positive**
- ☐ **Radiologist Notified**
- ☐ **Ordering Physician Notified**
- ☐ **Patient injected with consent signed**
- ☐ **Patient to reschedule to next menstrual cycle**

______________________________ ______________
X Tech Signature **Date**