Diagnostic nuclear medicine

Inclusive pregnancy and breast/chest feeding enquiry form

1. What is your preferred name? _____

2. What are your pronouns? He/Him She/Her They/Them Other _____

Your doctor/healthcare professional has requested a nuclear medicine study that requires an exposure to radiation. Radiographers must ensure we protect individuals from unnecessary exposures to radiation. This is particularly relevant when considering any potential risk to pregnancy where there is greater risk from the harmful effects of radiation.

As you are **aged between 12 and 55 years old**, please answer the following questions.

3. Which sex were you registered as at birth? **Female** / **Male** (circle)

If you are aware that you were born with a physical variation in your sex characteristics (VSC), also known by the terms diverse sex development (DSD) or intersex, please let the radiographer know. This can be discussed privately if you wish.

4. Are you breast/chest feeding or planning to breast/chest feed in the next month? **YES** / **NO**

Only answer the following if you have answered Female above, and/or have a VSC with the potential of pregnancy:

5. Have you had any previous surgery, treatment or medical conditions that resulted in you being unable to become pregnant? **YES** / **NO**

If YES, please move on to patient signature. If NO, please continue:

6. When was the 1st day of your last menstrual period? _____

7. Are you or might you be pregnant? **YES** / **NO**

Only continue with the following questions if you are unsure of the response to Question 5 or answered YES to Question 6:

8. Is your period overdue? **YES** / **NO** / **UNSURE**

9. Are you using any form of contraception? **YES** / **NO**

Patient signature _____ Date _____

Staff signature _____ Date _____

Making enquiries about pregnancy is a legal requirement. With your permission, a copy of this document will be stored electronically in your radiology notes. All your personal data is managed in line with data protection regulations. Please inform a radiographer if you do not consent, or consent to only part of this information being stored. Please note, we might not be able to continue, or it could delay your examination, if we are unable to confirm your pregnancy status.

Staff to complete:

Patient NHS number _____ **DOB** _____

Clinical need overrides LMP status **Date** _____

IR(MR)R practitioner's name _____ **Signature** _____