Department of Radiology: Radiation Safety Questionnaire

For patients 11-55 who are to be exposed to radiation between the diaphragm and pelvis to reduce the risk of accidental exposure to an unborn child

Making the enquiries below is a legal requirement before imaging involving radiation. With your permission, this document will be stored electronically in your radiology notes. Information about all aspects of your treatment is confidential and will not be shared with anyone except other healthcare professionals directly involved with your care including your own GP. All your personal data is managed in line with data protection regulations. Please note, we might not be able to continue, or it could delay your examination, if we are unable to confirm your pregnancy status

For accompanied children between the age 11-13, a Parent/Guardian is required to sign below.
Unaccompanied children between the age 11-13 should be referred back to referring clinician

Document label
Please attach here

Preferred name below (optional):

_____

Examination(s):

Which sex were you registered as at birth? (Please ✓)

Male ☐ Please **sign here**: _____ & return form to staff

Female ☐ Please complete **A** & sign **B** below

A: Are you or might you be pregnant?

YES ☐ **Discuss with Radiology staff**

NO ☐ **What date was the start of your last period ___/___/___ or select:** ☐ **N/A**

Please ✓ beside the reason you know you are not pregnant

Abstinence since last period		Periods haven't started	
Condom/diaphragm		Post-Menopausal	
Coil - Fitted/replaced as appropriate		Post-Partum	
Combined pill		Progesterone only contraceptive pill	
Depo Provera – within last 12 weeks		Same-sex partner only (registered female at birth)	
Hormone Implant – within last 3 years		Sterilised	
Mirena coil – fitted within last 5 years		Uterus (womb) has been removed/Hysterectomy	
Negative pregnancy test		Vasectomy (partner registered male at birth)	
None		Other reason (please provide reason below)	

Other reason: _____

B: Patient: _____ Operator: _____

Parent/Guardian: _____ Date: _____

STAFF USE ONLY - If clinical need overrides LMP status please ✓ the box: ☐

IR(ME)R Practitioner's name (PRINT) _____