SAINT CLARE'S HOSPITAL

PATIENT LABEL

PATIENT'S NAME:_____

DATE:_____

Due to the most recent information available, it has been determined ionizing radiation (x-ray or radioactive isotope) may be hazardous to unborn children.

In order to protect all our patients, it is required that all female patients fill out this form prior to x-ray examination.

The form should be completed by all female patients of an age where pregnancy is possible (ages 10-55).

If you have any questions, please feel free to check with your family physician about this matter.

DATE OF LAST NORMAL MENSTRUAL PERIOD_____

ARE YOU NOW PREGNANT? (urine pregnancy tests are available)

NO_____

NON-PREGNANCY VERIFICATION FORM

I state that to my knowledge, I am not pregnant, nor do I have any reason to believe that I may be pregnant. I have been offered the opportunity to have a pregnancy test and have declined. If this should be an error and I discover that I am pregnant, I hereby release any doctors who participated in my care, Saint Clare's Hospital and its Board of Trustees, Administration, employees, agents, and medical staff from any and all liability related to my decision. I understand further that this release shall be binding upon the patient's heirs, executor, administrators and assigns.

Patient's Signature or Guardian	Date	Time
Witness	Date	Time

YES_____

PREGNANCY AWARENESS FORM

I state that I am pregnant. Due to my accident or illness, my physician has ordered X-rays or radioactive isotope that might affect the fetus. I understand that all possible precautions will be taken to protect the fetus. I hereby agree to have the prescribed x-rays or radioactive isotope and release any doctors who participated in my care, Saint Clare's Hospital and its Board of Trustees, Administration, employees, agents, and medical staff from any and all liability related to my decision, including any damages due to radiation effects. I understand further that this release shall be binding upon the patient's heirs, executor, administrators and assigns.

Patient's Signature or Guardian	Date	Time
Witness	Date	Time

UNSURE_____

(If unsure please inform the Technologist) a urine pregnancy test will be required

Patient's Signature or Guardian	Date	Time
Witness	Date	Time

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