(A) Policy Statement

The radiologic technologist performing the requested radiologic procedure will question all females between the ages of 12 and 60 on pregnancy and last menstrual period. This information will be documented in the Radiology Information System.

(B) Purpose of Policy

To provide information necessary to eliminate all unnecessary radiation to the fetal population.

(C) Procedure

The technologist responsible for the procedure shall document the information in the RIS upon questioning the patient.

If the patient indicated that yes, she is pregnant

1. Radiologist should be consulted if any of the following procedures will be performed. If approved, it should be documented and proper patient education and consent should be obtained.
   a. Any general diagnostic exam centered over the abdomen or pelvis
   b. Any fluoroscopic procedure
   c. CT scan of the chest, abdomen, pelvis, thoracic spine, or lumbar spine
   d. Interventional procedure
   e. Nuclear medicine procedure

2. For any exam/procedure not listed above, technologist can proceed with exam. If unsure, consult radiologist.

If the patient indicates that she is not pregnant, unsure, or could potentially be pregnant

1. The last menstrual period (LMP) information should be obtained from the patient and documented. The technologist may proceed with the exam if either one of the following criteria is met:
   a. It has been less than 30 days since the onset of menses, OR
   b. If the exam is NOT one of the following:
      i. Any general diagnostic exam centered over the abdomen or pelvis
      ii. Any fluoroscopic procedure
      iii. CT scan of the chest, abdomen, pelvis, thoracic spine, or lumbar spine
      iv. Interventional procedure
      v. Nuclear medicine procedure

2. For adult patients, if the criteria above have not been met, but if the patient indicates that she is practicing any one of the following forms of birth control, then the exam may proceed:
   b. Birth control pills, shot, depot injection, or patch
   c. Intrauterine device (IUD)
   d. Tubal ligation or hysterectomy
   e. Not heterosexually active
3. For **Minors**, if the criteria in section #1 above is not met, recommend pregnancy testing
   a. Test should be ordered by appropriate clinician
4. If none of the criteria above have been met, then a pregnancy test is required.
   a. Results of pregnancy test performed within the past 72 hours are acceptable with the exception of tests performed at home.
   b. Urine or serum pregnancy test of all other exams

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**Approved by:**

/s/ Haitham Elsamaloty, MD  
Chairman & Professor, Radiology  
Date  
04/11/2023

/s/ Christine Stesney-Ridenour, FACHE  
Chief Operating Officer- UTMC  
Date  
04/04/2023

**Review/Revision Date:**

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**Next Review Date:** 3/1/2026

**Policies Superseded by This Policy:** M-001
CONSENT TO PERFORM
A RADIOLOGIC PROCEDURE
(On Pregnant Patients)

Please read carefully before signing.

PATIENT: __________________________________________ AGE: __________________

DATE: ___________________ TIME: ___________________ (____ am____ pm)

1. I authorize The University of Toledo Medical Center Department of Radiology to perform the radiologic
procedure known as (name/or description): _________________________________________________________

2. I understand that this procedure is for the diagnosis of: ____________________________________________

3. I consent to the administration of radiation to be applied by or under the direction and supervision of The
University of Toledo Medical Center radiologist ______________________________________________________

4. I further understand that any radiation to the fetus could cause damage (especially within the first trimester).
Potential adverse effects are: birth defects, retarded physical or mental growth, and/or childhood cancer. Most
research has demonstrated these effects only at doses to conceptus greater than 5,000-10,000 mrem. A single
x-ray film produces a dose of approximately 100 mrem. Risks from irradiation levels of 1,000 mrem are quoted
as 1 in 1,000 to 1 in 10,000. The rate of congenital defects from all other sources is 4-6 in 100.

5. I acknowledge that the technologist(s) has (have) explained to me the nature and purpose of the procedures(s)
and what the procedure(s) is (are) expected to accomplish together with the reasonably known risks as well as
my right to refuse the recommended procedure. I further acknowledge that all questions about the procedure(s)
have been answered in a satisfactory manner.

I hereby state that I have read, understood, and voluntarily signed this consent. All blanks were filled in prior to
my signature.

DATE: ___________________ TIME: ___________________ (____ am____ pm)

Signature of Patient: ____________________________________________________________

Signature of Technologist(s): ___________________________________________________

Signature of Witness: __________________________________________________________