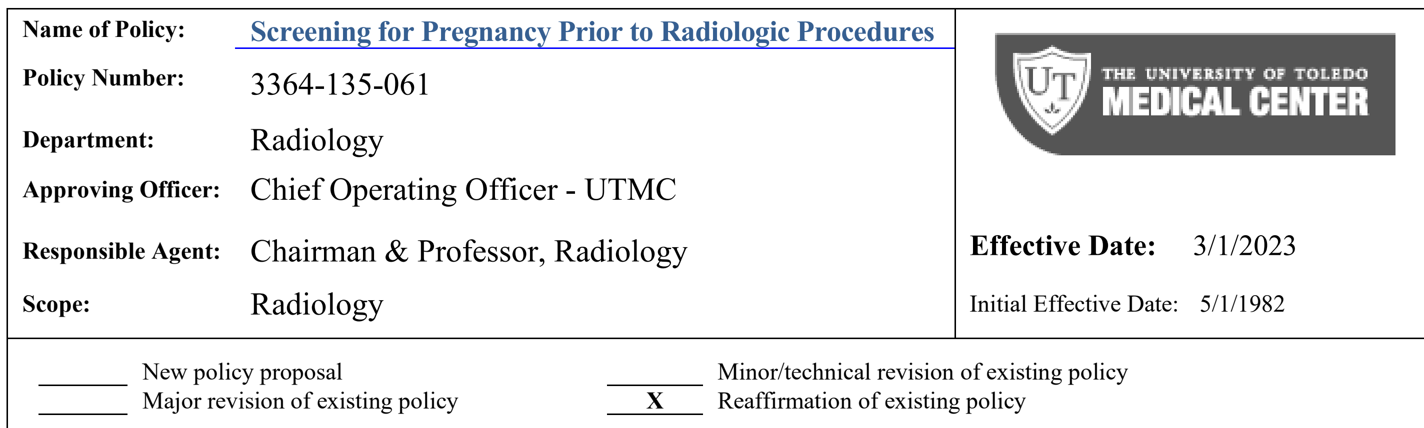

Name of Policy:	Screening for Pregnancy Prior to Radiologic Procedures	THE UNIVERSITY OF TOLEDO MEDICAL CENTER
Policy Number:	3364-135-061	
Department:	Radiology	
Approving Officer:	Chief Operating Officer - UTMC	
Responsible Agent:	Chairman & Professor, Radiology	Effective Date: 3/1/2023
Scope:	Radiology	Initial Effective Date: 5/1/1982

_______	New policy proposal	_______	Minor/technical revision of existing policy
_______	Major revision of existing policy	X	Reaffirmation of existing policy

(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:
   a. Not sexually active. Abstinent.
   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

Approved by:		**Review/Revision Date:**
/s/	04/04/2023	9/24/90 3/1/2023
Haitham Elsamaloty, MD Chairman & Professor, Radiology	Date	7/01/93 4/26/99 5/01/02 9/26/05
/s/	04/11/2023	5/23/08 5/1/2011
Christine Stesney-Ridenour, FACHE Chief Operating Officer- UTMC	Date	5/8/2014 11/17/2016 1/1/2017 3/1/2020
		Next Review Date: 3/1/2026
Policies Superseded by This Policy: M-001		

**CONSENT TO PERFROM
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: ____

Rev. 11/07 White – Radiology / Canary – Medical Records

Pregnant Patient Consent