

What is the IPS?

The Inclusive Pregnancy Status (IPS) Form is given to all patients aged 12-55. Before your imaging appointment, the radiographer will use this form to ask you some important questions about any potential pregnancy.

Why am I being asked this?

For our radiographers to safely perform the imaging test we need to ensure there is no possibility that you may be pregnant.

It also ensures the doctors reviewing your images are aware of your registered sex at birth, as sometimes this is relevant to your diagnosis.

Your answers will help us to help you.



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You will be given a form like this

Radiotherapy Inclusive Pregnancy Status (IPS) Form

Patient identification details: name, date of birth, hospital/NHS number (sticker)

Your clinician has requested radiotherapy treatment that requires an exposure to radiation. As radiographers it is our professional duty and legal responsibility to ensure that 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 - 55 years old**, please answer the following questions.

1. Which sex were you registered as at birth (circle)?

FEMALE

MALE

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

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

2. Are you or might you be pregnant?

YES/NO

Write your initials in the boxes below to show that you have read and understood the following statements. **It is important to ensure you do not become pregnant during your radiotherapy treatment. It is your responsibility to inform your doctor/healthcare professional if you are unsure of your pregnancy status or if it changes during your radiotherapy treatment.**

Please be aware that you may still be able to become pregnant if taking testosterone or undergoing chemotherapy.

Patient Signature: _____ Date: _____

Radiographer Signature: _____ Date: _____

*Making enquiries about pregnancy is a legal requirement. With your permission, a copy of this document will be stored electronically with your radiotherapy clinical 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 may not be able to continue, or it may delay your treatment if we are unable to confirm your pregnancy status.

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Diagnostic Imaging and Nuclear Medicine Inclusive Pregnancy Status (IPS) Form

1. What is your preferred name _____
2. What are your pronouns: He/Him She/Her They/Them Other _____

Your Doctor/Health Care Professional has requested an X-Ray or other similar investigation that requires an exposure to radiation. As radiographers it is our professional duty and legal responsibility to ensure that 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 - 55 years old**, please answer the following questions.

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

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

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

4. 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:

5. When was the 1st day of your last menstrual period? _____
6. Are you or might you be pregnant? **YES/NO**

Only continue with the following questions if the patient is unsure of the response or answers yes to Question 5:

6. Is your period overdue? **YES/ NO/ UNSURE**
7. Are you using any form of contraception? **YES/ NO**

Patient Signature _____ Date _____

Staff Signature _____ Date _____

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Staff to Complete:

Version Control reference