Nuclear Cardiology Lab

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Pregnancy and/or Breast Feeding Verification

MUST BE COMPLETED BY ALL FEMALE PATIENTS

Patient Name:_____ Birth Date:_____

1. Are you (check appropriate circle)
   - ◯ Post-Menopausal
   - ◯ Pre-menopausal, surgically sterile. (e.g. hysterectomy, tubal ligation, etc.)
   - ◯ Pre-menopausal, not surgically sterile

     If so, are you or do you think you may be pregnant?

     Yes ◯ No ◯ Date of your last menstrual period:_____
2. Have you ever had a mastectomy?(check appropriate circle) Yes ◯ No ◯

   Right ◯

   Left ◯

   Implant ◯

   Prosthesis ◯

   Are you currently breast feeding: Yes ◯ No ◯
3. I authorize the administration of Tc99m sestambi (cardiolite) or Tc99m tetrofosmin (myoview) or Thallium 201 to perform the Nuclear Cardiac stress test. The nature and purpose of this procedure and possibility of any complications have been explained to me and I have had the opportunity to ask questions. To my knowledge, I am not pregnant at this time.

Patient Signature:_____Date:_____