THE
WOMAN'S
GROUP

Obstetrics, Gynecology, Infertility, & Menopause

EXCELLENCE IN WOMEN'S HEALTHCARE

CONSENT FORM FOR ELECTIVE ULTRASOUND

I hereby authorize The Woman's Group to perform a 4D ultrasound on me and my baby. I elect to have this procedure and I understand that its purpose is not diagnostic in nature, that is, the procedure is not intended to detect obstetrical problems or fetal birth defects. I fully understand that this procedure is for the purpose of obtaining a three dimensional view of my baby in the womb over the period of time scheduled by my appointment and that this service is not covered by insurance providers.

I acknowledge that during this appointment, an optimal view of my baby may not be available due to the baby's position in the womb and due to the amount of amniotic fluid present. The optimal gestational age is 28-32 weeks.

I hereby acknowledge that I have read and understand the information in this document and that through my signature, I agree to all of the terms stated.

Patient Signature: _____Date: _____

Patient Name (PRINT):_____

Date of Birth: _____

Witness:_____