Consent for Ultrasound

I have been fully informed and thereby give my consent to a diagnostic procedure known as Sonography. I understand that an ultrasound scan of my abdomen and baby and/or a vaginal sonogram will be done using quality-controlled sonographic equipment. I understand why this procedure has been prescribed for me/my baby/babies.

I understand and accept the following points which have been explained to me:

1. Ultrasound exposure involves no known risk to the mother or fetus.
2. The information obtained by the nurse/technician will be reviewed by one of our physicians and/or physician assistants.
3. My physician or midwife will receive a report from the physician.
4. There are limits to the ability of sonography to accurately reproduce internal views of body structures, amniotic fluid amounts or physiologic activities. Sonography cannot detect all fetal anomalies.

I have read the above information and understand it fully. I hereby authorize Park Avenue Maternal-Fetal Medicine and their designated technicians, nurses, physician assistants and/or physicians to perform the procedure.

Patient's Signature:_____

Witness's Signature:_____

Date:_____

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