



Baby Pictures Ultrasound
Bellegrove Professional Building
1515 116th Ave NE, Suite 203
Bellevue, WA 98004
Tel: (425) 462-9116
Fax: (425) 462-6639
melissa@babypicturesultrasound.com
www.babypicturesultrasound.com

PRENATAL CARE VERIFICATION REPORT/PATIENT CONSENT FORM

To: Baby Pictures Ultrasound
RE: 4D Ultrasound

\_\_\_\_\_ is currently a patient under my care for her pregnancy, and I am aware she will be scheduling a 2D, or 3D/4D ultrasound at Baby Pictures.

Patient has had a normal second trimester anatomy ultrasound. Yes \_\_\_\_\_ No \_\_\_\_\_

Patient has normal Integrated Screening or Quad Screen. Yes \_\_\_\_\_ No \_\_\_\_\_

Provider (Print) Date

Signature Date

Phone

PATIENT CONSENT TO RELEASE FORM

I authorize the above named physician and his/her staff to release the information above to Baby Pictures Ultrasound. Furthermore, I authorize that this information may be provided, via fax, to Baby Pictures Ultrasound.

Patient (Print) Date

Signature Date