Alamo Women's Clinic of Albuquerque
10151 Montgomery Blvd NE
Albuquerque, NM 87111

REQUEST FOR ULTRASOUND EXAMINATION

Date: _____

Patient Name: _____

Date of Birth: _____

I understand that a diagnostic ultrasound is a procedure that enables the clinician to view my pregnancy in order to determine the age of the fetus and to look at other structures in my uterus. This is done with an instrument that sends sound waves through the amniotic fluid (water bag).

I understand that this ultrasound is being done only to determine the age of the fetus and not abnormalities of my pregnancy, fetus, or reproductive tract. More extensive studies may be needed to diagnose specific conditions or abnormalities in the pregnancy. If more extensive studies are needed, I understand that I will be referred to a specialist for further testing. I also understand there are limitations to all imaging techniques.

While there is no evidence at present to prove negative effects of ultrasound on a developing fetus, I am aware there may be unrecognized risk with long term exposure in any procedure.

I have read and understand the above information.

I authorize the attending physician and/or trained medical staff from any liability arising out of or connected with this procedure and particularly with regard to any abnormalities of my pregnancy, fetus, or reproducing tract that have not been evaluated by this study.

I hereby request that the physician and/or trained medical staff authorized by the attending physician and/or Medical Director to perform an ultrasound screening on me for the sole purpose to determining the age of the fetus.

_____ _____
Signature of Patient Date

I witness the fact that the patient has read the above information and said that she has read and understands same.

_____ _____
Signature of Witness Date