IMAGING ASSOCIATES
OF PROVIDENCE
A Providence Partner

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Prenatal Care Verification Form

Using the latest in 3D/4D fetal imaging, Imaging Associates of Providence allows your patients the opportunity to view their baby during a non-diagnostic ultrasound session. Our goal during this session is to provide parents a keepsake of their baby. This does not include measurements, determination of due dates, or any other related diagnostic information. This service is not intended as a replacement for a diagnostic exam. It is our policy that all women requesting an elective keepsake ultrasound provide documentation that they are receiving prenatal care. This form is a prerequisite before services can be completed. If any emergent abnormalities are seen during this session, the patient's healthcare provider will be notified immediately.

My patient _____ is currently receiving prenatal care for her pregnancy as directed. I hereby authorize my patient's request to obtain an elective keepsake ultrasound with Imaging Associates of Providence.

PROVIDER SIGNATURE

PHYSICIAN/CNM PRINTED NAME
PHYSICIAN/CNM SIGNATURE
PHONE #

SPECIAL CONCERNS