

* BUBBIE'S BEBES *

522 W. Chickasha Ave.

Chickasha, OK, 73018

(405) 274-5664

(Inside Emmas Essentials)

Fax (866) 594-1023

Physician Consent /Order form

Patient Name _____ Appt. Date _____

Package requested _____ US this Pregnancy _____

Patient DOB _____ EDD _____ Fetal Age Weeks _____

Patient Address/Phone _____

OB Provider Name _____

OB Provider Address _____

OB Provider Phone _____ Fax _____

Any physician instructions? _____

Purpose: Patient requesting Elective Ultrasound _____

This letter serves to inform you that this patient has requested an elective 2-D, 3-D or 4-D Ultrasound in our facility. I uphold that this facility is staffed by an ARDMS registered and compliant sonographer and is directed by Board Certified Radiologists and guided by the advice of an Obstetrician and Gynecologist. A limited exam showing fetal cardiac activity, number, gender will be done, and should any finding of concern be observed, our Medical Director will contact you personally. Our company requires that prenatal care be confirmed by you when clients request our service. They understand that this elective exam in no way replaces your diagnostic ultrasounds and that by signing this letter their Provider is validating that the patient IS in their prenatal care and is authorizing our Sonographer to perform this elective Ultrasound. After signing please fax it back as soon as possible. Thank you for allowing us to be a part of this family's journey.

Signed _____ +