Southern Colorado Maternal Fetal Medicine
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Obstetrical Ultrasound Consent

I, ____, authorize Southern Colorado Maternal Fetal Medicine to perform an ultrasound examination. The ultrasound ordered by my clinician is being performed for one or more possible diagnostic reason, including but not limited to:

Estimated Gestational Age

Targeted evaluation

Biophysical Profile

Guide to an invasive Procedure (amniocentesis, cordocentesis)

Diagnostic Ultrasound in the field of obstetrics is the use of high-frequency sound waves to obtain information on the fetus. Diagnostic ultrasound can provide very important information concerning the health and well-being of the fetus

I have read and understand the following:

At the present time there are no known hazardous biological risks from the use of diagnostic ultrasound; however, it is impossible to exclude the possibility of further findings to the contrary. Medical research and data currently suggest that there is no physical harm to the fetus from diagnostic ultrasound.

The ultrasound examination cannot guarantee that there are no fetal disorders or abnormalities. Many disorders cannot be detected by obstetrical ultrasound (e.g. autism, developmental delay, blindness, hearing loss, attention deficit disorder.) In addition, the ultrasound examination may suggest fetal disorders or abnormalities that, after birth, are not present or are completely harmless. Ultrasound is also a type a fetal genetic screening test.

I understand that additional testing and/or procedures may be advised based on the result of this examination. If this is the case, the reason will be explained to me by the physician or staff member to my satisfaction.

I have had the opportunity to ask questions, and I am satisfied with the explanation given to me.

____   _________________________

Signature of Patient   *Date*