GIG RADIOLOGY

CLIENT INFORMATION SHEET 3/4D ULTRASOUND

Name:_____

Home Address:_____

Phone:_____(Mobile)_____

Date of Birth:_____

Today's Date:_____

Are you receiving prenatal care? (circle) YES / NO

Doctor's Name:_____

Doctor's Address:_____

Doctor's Phone:_____

Due Date:_____

Have you received a 10 weeks and 18-20 weeks medical ultrasound scan?
(circle) YES / NO

Were there any abnormalities evident during these scans? (circle) YES / NO

I have chosen to obtain an elective non-medical 3D/4D fetal ultrasound.

I understand this has not been requested by my physician.

I understand that this ultrasound is not to replace physician care.

I have read and understood the above.

Signature:_____Date:_____