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Prenatal Care Verification Form

Elective 2D/3D/4D Ultrasound

Medical Provider Name _____

Your patient, _____, has requested an elective, limited 2D and/or 3D/4D ultrasound be performed at WeeBaby Imaging, LLC.

Using the latest in 2D and 3D/4D fetal imaging technology, WeeBaby Imaging, LLC allows your patients to view their baby in a comfortable and personalized ultrasound session. We offer elective, limited ultrasound exams that are not intended as a replacement for a full diagnostic fetal ultrasound.

WeeBaby Imaging, LLC offers the highest quality in ultrasound imaging. Our sonographers are registered with ARDMS and provide experienced, professional service. It is our goal to provide our clients with the best quality ultrasound imaging experience and to give them and their family the opportunity to bond with their baby in a comfortable and caring environment. It is one of the most memorable and exciting times in an expecting couple's life.

We require all of our clients to receive prenatal care and that their healthcare provider be informed that an elective ultrasound has been requested. If this is not a patient under your care or if you should have any questions regarding our services, please contact us. The services provided by WeeBaby Imaging, LLC are at no liability to you or your office.

All of the images obtained from WeeBaby Imaging, LLC are reviewed by our Medical Director, a Board Certified Radiologist. Although the purpose of this elective, limited ultrasound is not to determine obstetrical problems or fetal abnormalities, if any problems are detected the patient's healthcare provider will be informed.

I acknowledge that the patient listed above is currently under my care for her pregnancy. I authorize my patient's request to obtain an elective ultrasound at WeeBaby Imaging, LLC.

Obstetrician/Healthcare Provider's Signature