INFORMED CONSENT FOR ULTRASOUND / SONOGRAM

PATIENT NAME:_________________________________ DOB:______________

Your physician has requested that we perform an ultrasound/sonogram (US) to obtain additional information. This is a diagnostic test that uses sonar graphic waves and a computer to produce images of internal body parts.

The benefit of this exam is to assist your physician with making a diagnosis. There may be other imaging alternatives, however, your physician believes that a sonogram to be the best diagnostic test for you after evaluating your symptoms and medical condition at this time.

By my signature below, I hereby certify that I have fully read this consent, had it explained to me or have had it read to me. I have been given an opportunity to ask questions about my condition, alternative forms of treatment, the procedures to be used, and the risks and hazards involved. I understand its contents and have sufficient information to give this informed consent.

__________________________________DATE:_____________TIME:___________
Patient/Parent/Legal Guardian Signature

___________________________________DATE:____________ TIME:___________
Witness Signature

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