

ULTRASOUND CONSENT FORM

POLARIS ULTRASOUND LLC

CONTACT

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Patient Name: _____

Gender: _____

Date of Birth: _____ / _____ / _____

Phone: (_____) - _____ - _____

Address, City, STATE, Zip: _____

Your physician has requested that we perform an ultrasound/sonogram (US) to obtain additional information. This is a diagnostic test that uses sound 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. 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.

Patient/ Parent/ Legal Guardian Signature

Technologist