



LIMITED OBSTETRIC ULTRASOUND CONSENT

I have requested that Fresno Women's Medical Group perform an ultrasound of my unborn baby.

I understand that this ultrasound is a limited obstetrical ultrasound, to evaluate only limited aspects of the pregnancy. It is not to see if the baby has any abnormalities. Major and/or minor abnormalities that could be seen on a complete ultrasound or an ultrasound read by a radiologist may be missed by this limited ultrasound.

I understand that it may not be possible to determine fetal sex on this ultrasound. I also understand that if the sex of the unborn baby is predicted, this prediction may not be correct. I agree not to hold Fresno Women's Medical Group or its employees responsible if the prediction is wrong.

Pictures may be taken of the fetus during this ultrasound. Fresno Women's Medical Group may, or may not, keep copies of these pictures. These may show abnormalities that Fresno Women's Medical Group or its employees may not recognize. If any abnormality, no matter how severe, is missed by this ultrasound or is not recognized on the pictures, I agree not to hold Fresno Women's Medical Group or its employees responsible.

I have thoroughly read the information above and understand the limitations of the ultrasound I am about to have.

Name (print) _____ DOB _____

Signed _____ Date _____

Witness _____ Date _____