



little sprout imaging

TEL: 410.825.8686

**7801 York Road, Suite 127
Towson, MD 21204**

info@lsprout.com
www.littlesproutimaging.com

PRENATAL CARE VERIFICATION & PATIENT CONSENT

To: Little Sprout Imaging
RE: 3D/4D Ultrasound

_____ is currently a patient under my care for her pregnancy. She has undergone a full anatomy medical ultrasound during the second trimester of her pregnancy. Southern PA practices that **do not** perform this study please cross out the line above and initial.

The results of the ultrasound were:

_____ NORMAL

_____ ABNORMAL

If abnormal, please explain briefly:

Provider Signature

Physician/CNM Printed Name

Physician/CNM Signature

Phone Number

Patient Consent to Release Information

I authorize the physician named at left and his/her staff to release the information provided here to Little Sprout Imaging.

Thank you,

Print Name

Date

Signature