



700 Highlander Blvd. Suite# 150
Arlington, TX 76015
Phone #: 817-465-VIEW (8439)
FAX #: 817-465-8438

Physician Order for Limited Diagnostic Ultrasound

TO: ULTRAVIEW IMAGING

RE: 2D, 3D/4D ELECTIVE ULTRASOUND

_____ is currently a patient under my care for her pregnancy. She has undergone a diagnostic ultrasound during her pregnancy, and I authorize her to have a limited diagnostic ultrasound at Ultraview Imaging. This limited diagnostic ultrasound will not take the place of a level one ultrasound.

The results of the ultrasound were: **NORMAL.** _____ **ABNORMAL** _____

PROVIDER SIGNATURE

Name: _____

Signature: _____

Address: _____

City & Zip code: _____

Phone #: _____

We would like to assure you that our technologists are registered sonographers. If you have any questions about our services, please contact us by calling (817) 465-8439 or visit our website at www.ultraviewimaging.com

Patient Consent to Release Information

I authorize the above named health care provider and his/her staff to release the information above to Ultraview Imaging. Furthermore, I authorize that this information may be provided to Ultraview Imaging via fax or by patient.

Thank you,

Patient Name: _____ Date: _____

Patient Signature: _____

Please Return Fax To: (817) 465-8438

M. L. Waller RDMS, RVT, LVN