



**PRENATAL CARE VERIFICATION FORM**

YOUR PATIENT \_\_\_\_\_ HAS REQUESTED A  
NON-DIAGNOSTIC 3D/4D ULTRASOUND. PLEASE VERIFY YOUR PATIENT IS RECEIVING  
PRENATAL CARE.

**PHYSICIAN/MIDWIFE** \_\_\_\_\_

ONCE COMPLETED FAX OR BRING WITH YOU ON YOUR NEXT  
APPOINTMENT.

COASTAL IMAGING  
20020 VETERANS BLV, SUITE 2  
PORT CHARLOTTE FLORIDA 33954  
Website [www.Florida4D.com](http://www.Florida4D.com)  
[Lisa@Florida4D.com](mailto:Lisa@Florida4D.com)  
PHONE 941-629-8001  
FAX 941-766-0001

**NOTICE TO PHYSICIANS:**

AT YOUR REQUEST WE WILL BE PLEASED TO PROVIDE A DIAGNOSTIC STUDY IN OUR  
FACILITY. TO SEE HOW THIS SERVICE WILL PROFIT YOUR PRACTICE CALL US OR VIEW  
OUR WEBSITE IN THE PHYSICIANS SECTION.