

**EASTERN VIRGINIA MEDICAL SCHOOL**  
**DIVISION OF MATERNAL-FETAL MEDICINE**  
**DIVISION OF GENERAL OBSTETRICS & GYNECOLOGY**  
**DIVISION OF UROGYNECOLOGY**

**Patient Name:** \_\_\_\_\_ **Date:** \_\_\_\_\_

It is our job to maintain your privacy, yet we strive to provide you with information in a timely, efficient manner. Therefore, we would like for you to provide us with the information below. This will help us to communicate with you and any other person that you designate, especially if you are having testing and we will be calling you with test results. If any of this information changes, please update this for us.

**Please provide us with any phone numbers that you would like us to call when trying to reach you:**

|             | May we leave a message? |    |
|-------------|-------------------------|----|
| Home: _____ | Yes                     | No |
| Work: _____ | Yes                     | No |
| Cell: _____ | Yes                     | No |

If you would like for us to leave information with your partner (or another designated person) about your results or follow-up appointments, please provide their full name here:

Name: \_\_\_\_\_

|             | May we leave a message? |    |
|-------------|-------------------------|----|
| Home: _____ | Yes                     | No |
| Work: _____ | Yes                     | No |
| Cell: _____ | Yes                     | No |

If you are having prenatal testing, would you like us to inform you of the baby's sex?

Yes                      No                      Undecided