



CENTER FOR
WOMEN'S HEALTH

Comprehensive, personalized care you can trust

Leslie R. Coffman, M.D.
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If Dr. Coffman's office needs to contact me regarding my pap smear, lab tests, or x-ray results, I wish to be contacted by: (please check one)

_____ Telephone 1st Number _____
During Hours _____
Yes / No Dr. Coffman's office has permission to leave a message.

2nd Number _____
During Hours _____
Yes / No Dr. Coffman's office has permission to leave a message.

3rd Number _____
During Hours _____
Yes / No Dr. Coffman's office has permission to leave a message.

_____ Mail Address to which Dr. Coffman's office needs to mail a notice:

Patient Name: _____

Patient Signature: _____

Date: _____