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| --- |
| To Whom It May Concern |
| **PATIENT INFORMATION** | [Date] |
|  |  |
| Patient Name (Last, first, middle initial) | Social Security # or Patient ID |
|  |  |
| Street address, City, ST, ZIP Code |  |
|  |  |
| Primary phone number | Another phone number | Date of Birth |

|  |  |  |
| --- | --- | --- |
|  |  |  |
| Estimated Conception Date [ECD] |  | Note |
|  |  |  |
| Estimated Delivery Date [EDD] |  |  |
| Current Age of Mother-to-be |  | Note |
|  |  |  |
| Fetus Age |  | Health |

I assure that the above-mentioned patient has tested positive in her pregnancy. All the information provided about the patient is correct and accurate.

**[Medical Service Provider Name]**