WEST VIRGINIA DEPARTMENT OF HEALTH
BUREAU FOR PUBLIC HEALTH
OFFICE OF MATERNAL, CHILD, AND FAMILY HEALTH
BUREAU FOR PUBLIC HEALTH
FAMILY PLANNING PROGRAM

INTRAUTERINE DEVICE (IUD) IN-TAKE FORM

All areas must be completed prior to submission. **TODAY'S DATE:_____**

CLIENT NAME: _____ DATE OF BIRTH:_____
(LAST) (FIRST) (MI) MM DD YYYY

S.S. NO.: _____-____-_____ GROSS MONTHLY INCOME: _____ FAMILY SIZE:_____

CLINICIAN REFERRAL: _____

IUD INSERTION: _____ MIRENA: _____ PARAGARD: _____ LOT NUMBER: _____

IUD REMOVAL: _____ MIRENA: _____ PARAGARD: _____

FAMILY PLANNING SITE: _____

CLINIC NUMBER: _____

REMARKS: _____

RETURN INTAKE FORMS TO: 350 CAPITOL STREET, ROOM 427, CHARLESTON, WV 25301
ATTN: WVFPP BILLING SPECIALIST OR SEND VIA FAX TO: (304) 957-7505**

*** PLEASE NOTE: THIS FORM CONTAINS PERSONALLY IDENTIFIABLE INFORMATION (PII) AND CANNOT BE EMAILED. THIS FORM MAY BE SENT VIA REGULAR MAIL OR FAX TO THE NUMBER ABOVE. THIS FORM IS INTENDED FOR WV FAMILY PLANNING PROGRAM INTERNAL USE ONLY. THE USE OF THIS FORM IN ANY WAY OTHER THAN AS INDICATED IS A VIOLATION OF STATE AND FEDERAL LAW AND MAY BE PUNISHABLE BY FINES OR CONFINEMENT.**

****THIS FAX IS ENCRYPTED FOR SAFE TRANSMISSION OF INFORMATION.**

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