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

SUB-DERMAL HORMONAL IMPLANT (NEXPLANON) 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:**_____

CONFIDENTIAL SERVICES PATIENT?: YES _____ **NO** _____

NAME OF CLINICIAN PROVIDING INSERTION SERVICES: _____

NEXPLANON INSERTION: _____ **ORIGINAL INSERTION DATE:** _____

NEXPLANON REMOVAL: _____

FAMILY PLANNING SITE ISSUING REFERRAL: _____

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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