

REFERRAL FOR 17 alpha hydroxy-progesterone caproate

Name: _____ D.O.B.: _____
 Patient telephone: _____
 Patient address: _____
 Insurance: _____ Medicaid ID # : _____

# of Preterm Deliveries	
Gestational age of preterm deliveries (before 37wks)	
EDD (please circle) By LMP Confirmed by USD @ ____wks (start b/w 16-20wks EGA)	
Weeks gestation at time of order:	
Referral Source:	

****Please order 17 alpha hydroxy-progesterone caproate 250mg IM injection q week 10 cc vial with one refill to **begin at week 16** (NO LATER THAN WEEK 24) and **continue until week 36** by EDD. Please circle ordering pharmacy****

FOR ALL PRIVATE INSURANCE PATIENTS
 Triangle Pharmacy #(919) 858-0809 or
 Natures Pharmacy # (828)251-0094

FOR ALL UNINSURED PATIENTS
 NC Progesterone Program at www.mombaby.org

FOR ALL MEDICAID PATIENTS
 Triangle Pharmacy via NC Prog. Program @
www.mombaby.org

PHYSICIAN SIGNATURE _____ **DATE** _____