South Carolina Partners
for Preterm Birth Prevention

Patient Enrollment Form

(Please Print Legibly)

Treating Physician: First _________________Last_____________________________________

Phone: (_______)____

Physician Address: ____

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Patient Name: ___________________________________ Date of Birth: ________________

Street Address: ____

City/State/Zip: _______________________________________ County:__________________

Home Phone: (_____)____

Alternative Phone: (_____)____

EDC: _______________________

Diagnosis: ____

Medicaid Plan Name________________________________ ID#________________________

Preferred Language: ☐ **English** ☐ **Spanish** ☐ **Other _____________**

Has member been hospitalized during this pregnancy? ☐ **Yes** ☐ **No**

REFERRAL FOR <u>ENROLLMENT</u> INTO THE SOUTH CAROLINA PARTNERS FOR PRETERM BIRTH PREVENTION

PLEASE FAX TO: 770-767-4966

Form completed by____