

Total Women's Care, Inc
1445 Harrison Ave NW #302
Canton, Ohio 44708
330-452-9900
fax 330-452-9945

Patient Name _____

Patient was given Depo Provera 150mg Contraception Injection on _____
Next injection due in 12 weeks approximately _____

Lot Number _____ NDC # _____
Expiration Date _____

Location: ___ Right deltoid ___ Left deltoid ___ Right buttocks ___ Left buttocks

Please have the Individual administering product Print/ Sign their name and indicate designation.

_____ RN LPN MA
Print Name

Signature

Please return form to the office as soon as possible by either mailing or faxing. Any questions please call the office.

Thank you