

## WIC REFERRAL FOR POSTPARTUM/BREASTFEEDING WOMEN

**Health Care Provider:** Please provide the information requested below for your patient. This information will be used by our program staff to assess your patient's health status and to provide nutritional counseling. An incomplete referral may delay program benefits to your patient. A completed referral does not guarantee WIC Program benefits since program eligibility requirements must be met.

Patient's name (last, first)	Address (street, city, ZIP code)	Telephone number	Birthdate (MM/DD/YY)
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<b>WOMAN'S CURRENT</b> (After Delivery) Height _____ ins. _____ Weight _____ lbs.      Measurement date _____ Hemoglobin _____ gm/dl. _____ and/or _____ Hematocrit _____ %      Blood test date _____	<table style="width: 100%; border-collapse: collapse;"> <tr> <th colspan="5" style="text-align: center; border-bottom: 1px solid black;">PREGNANCY OUTCOME</th> <th style="text-align: right; border-bottom: 1px solid black;">Delivery date _____</th> </tr> <tr> <th style="text-align: center; border-bottom: 1px solid black;">Full-term</th> <th style="text-align: center; border-bottom: 1px solid black;">Preterm (37 wks.)</th> <th style="text-align: center; border-bottom: 1px solid black;">Sm. Gest. Age</th> <th style="text-align: center; border-bottom: 1px solid black;">Fetal Loss</th> <th style="text-align: center; border-bottom: 1px solid black;">Stillbirth</th> <th style="border-bottom: 1px solid black;"></th> </tr> <tr> <td style="border-bottom: 1px solid black;">1. <input type="checkbox"/></td> <td style="border-bottom: 1px solid black;"><input type="checkbox"/></td> <td style="border-bottom: 1px solid black;"><input type="checkbox"/></td> <td style="border-bottom: 1px solid black;"><input type="checkbox"/></td> <td style="border-bottom: 1px solid black;"><input type="checkbox"/></td> <td style="border-bottom: 1px solid black; text-align: center;">Sex _____</td> </tr> <tr> <td style="border-bottom: 1px solid black;">2. <input type="checkbox"/></td> <td style="border-bottom: 1px solid black;"><input type="checkbox"/></td> <td style="border-bottom: 1px solid black;"><input type="checkbox"/></td> <td style="border-bottom: 1px solid black;"><input type="checkbox"/></td> <td style="border-bottom: 1px solid black;"><input type="checkbox"/></td> <td style="border-bottom: 1px solid black; text-align: center;">Sex _____</td> </tr> <tr> <td colspan="5" style="border-bottom: 1px solid black;">Please describe any medical conditions affecting the infant(s): _____</td> <td style="border-bottom: 1px solid black; text-align: center;">Birth weight _____</td> </tr> <tr> <td colspan="5"></td> <td style="border-bottom: 1px solid black; text-align: center;">Birth length _____</td> </tr> </table>	PREGNANCY OUTCOME					Delivery date _____	Full-term	Preterm (37 wks.)	Sm. Gest. Age	Fetal Loss	Stillbirth		1. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Sex _____	2. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Sex _____	Please describe any medical conditions affecting the infant(s): _____					Birth weight _____						Birth length _____
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<b>PLEASE INDICATE ANY MEDICAL CONDITIONS AFFECTING THIS WOMAN.</b>  <input type="checkbox"/> C-Section <input type="checkbox"/> Other conditions occurring during this pregnancy for delivery (specify): _____ <input type="checkbox"/> Diabetes <input type="checkbox"/> Hypertension <input type="checkbox"/> Other current or historical medical conditions (specify): _____ <input type="checkbox"/> Tuberculosis  _____ +PPD      _____ INH	<b>PLEASE LIST ANY CURRENT MEDICATIONS/SUPPLEMENTS PRESCRIBED:</b>  <b>IMPRESSIONS/COMMENTS:</b>  <table style="width: 100%; border-collapse: collapse; border-top: 1px solid black;"> <tr> <td style="width: 80%; padding: 5px; border-bottom: 1px solid black;">Name of physician/health care provider/group/clinic</td> <td style="width: 20%; padding: 5px; border-bottom: 1px solid black;">Telephone number:</td> </tr> <tr> <td style="padding: 5px;"> </td> <td style="padding: 5px;"> </td> </tr> </table>	Name of physician/health care provider/group/clinic	Telephone number:		
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<b>LOCAL WIC AGENCY</b>	<b>IMPORTANT:</b> Must be signed by health care provider _____ Date _____				

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