WIC REFERRAL FOR PREGNANT 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)

WOMAN'S CURRENT (PRENATAL)

Height _____ ins. Measurement date _____

Weight _____ lbs.

Hemoglobin _____ gm/dl. Blood test date _____

and/or

Hematocrit _____ % _____

Est. date confinement _____

Date last preg. ended _____

Gravida _____ Para _____

Pregravid weight _____ lbs.

PLEASE INDICATE ANY MEDICAL CONDITIONS AFFECTING THIS WOMAN:

- ☐ Diabetes
- ☐ Multiple Pregnancy
- ☐ Hypertension
- ☐ Tuberculosis _____ +PPD _____ INH
- ☐ Previous poor pregnancy outcome / history (specify):
- ☐ Other current or historical conditions (specify):

PLEASE LIST ANY CURRENT MEDICATIONS / SUPPLEMENTS PRESCRIBED:

IMPRESSIONS/COMMENTS:

Name of physician/health care provider/group/clinic	Telephone number

LOCAL WIC AGENCY

San Bernardino County WIC Program
1-800-472-2321
wic.sbcounty.gov

IMPORTANT: Must be signed by health care provider Date

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CDPH

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CDPH 247C Rev 04/17 I #930028

CALIFORNIA WIC WOMEN, INFANTS & CHILDREN

PRINT FORM RESET FORM