

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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WOMAN'S CURRENT (After Delivery) Height _____ ins. Weight _____ lbs. Measurement date _____ Hemoglobin _____ gm/dl. and/or _____ Hematocrit _____ % Blood test date _____	<table style="width: 100%;"> <tr> <th colspan="5" style="text-align: center;">PREGNANCY OUTCOME</th> <th style="text-align: right;">Delivery date _____</th> </tr> <tr> <th style="text-align: center;">Full-term</th> <th style="text-align: center;">Preterm (37 wks.)</th> <th style="text-align: center;">Sm. Gest. Age</th> <th style="text-align: center;">Fetal Loss</th> <th style="text-align: center;">Stillbirth</th> <th></th> </tr> <tr> <td style="text-align: center;">1. <input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;">Sex Birth weight Birth length</td> </tr> <tr> <td style="text-align: center;">2. <input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;">Sex Birth weight Birth length</td> </tr> </table> <p>Please describe any medical conditions affecting the infant(s): _____</p>	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 Birth weight Birth length	2. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Sex Birth weight Birth length
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PLEASE INDICATE ANY MEDICAL CONDITIONS AFFECTING THIS WOMAN. <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	PLEASE LIST ANY CURRENT MEDICATIONS/SUPPLEMENTS PRESCRIBED: IMPRESSIONS/COMMENTS: <table style="width: 100%;"> <tr> <td style="width: 80%; padding: 5px;">Name of physician/health care provider/group/clinic</td> <td style="width: 20%; padding: 5px;">Telephone number:</td> </tr> </table>	Name of physician/health care provider/group/clinic	Telephone number:
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LOCAL WIC AGENCY	IMPORTANT: Must be signed by health care provider Date _____
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