

WIC REFERRAL FOR POSTPARTUM/BREASTFEEDING WOMAN

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																		
WOMAN'S CURRENT (After Delivery)	PREGNANCY OUTCOME																				
Height _____ ins.	_____ / _____ / _____ Delivery date																				
Weight _____ lbs.	<table border="0" style="width:100%; font-size: small;"> <tr> <td style="width:15%;">Full-Term</td> <td style="width:15%;">Preterm (37 wks.)</td> <td style="width:15%;">Sm. Gest. Age</td> <td style="width:15%;">Fetal Loss</td> <td style="width:15%;">Stillbirth</td> <td style="width:15%;"></td> </tr> <tr> <td>1. <input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>Sex _____</td> </tr> <tr> <td>2. <input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>Sex _____</td> </tr> </table>	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 _____	_____ / _____ Birth weight	_____ / _____ Birth length
Full-Term	Preterm (37 wks.)	Sm. Gest. Age	Fetal Loss	Stillbirth																	
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2. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Sex _____																
Hemoglobin _____ gm/dl.	Please describe any medical conditions affecting the infant(s):																				
and/or _____																					
Hematocrit _____ %																					
_____ / _____ / _____ Blood test date																					
PLEASE INDICATE ANY MEDICAL CONDITIONS AFFECTING THIS WOMAN.	PLEASE LIST ANY CURRENT MEDICATIONS/SUPPLEMENTS PRESCRIBED:																				
<input type="checkbox"/> C-Section	_____																				
<input type="checkbox"/> Diabetes	_____																				
<input type="checkbox"/> Hypertension	_____																				
<input type="checkbox"/> Tuberculosis	_____																				
_____+PPD _____INH	_____																				
<input type="checkbox"/> Other conditions occurring during this pregnancy or delivery (specify): _____	IMPRESSIONS/COMMENTS:																				
<input type="checkbox"/> Other current or historical medical conditions (specify): _____	_____																				
LOCAL WIC AGENCY	Name of physician/health care provider/group/clinic																				
	Telephone number: _____																				
	IMPORTANT: Must be signed by health care provider		Date _____																		

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