State of California—Health and Human Services Agency

Department of Health Services
WIC Supplemental Nutrition Branch

WIC REFERRAL FOR PREGNANT 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)	Telephone number	Birthdate

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):

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- ❒ Other current or historical conditions (specify):

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PLEASE LIST ANY CURRENT MEDICATIONS/SUPPLEMENTS PRESCRIBED:

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____

____

IMPRESSIONS/COMMENTS:

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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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