

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)
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WOMAN’S CURRENT (PRENATAL)

Height _____ ins. Measurement date _____ Hemoglobin _____ gm/dl. Blood test date _____ and/or _____ Weight _____ lbs. _____ Hematocrit _____ % _____	Est. date confinement _____ Date last preg. ended _____ Gravida _____ Para _____ Pregravid weight _____ lbs.
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<p>PLEASE INDICATE ANY MEDICAL CONDITIONS AFFECTING THIS WOMAN:</p> <p><input type="checkbox"/> Diabetes <input type="checkbox"/> Multiple Pregnancy</p> <p><input type="checkbox"/> Hypertension <input type="checkbox"/> Tuberculosis _____ +PPD _____ INH</p> <p><input type="checkbox"/> Previous poor pregnancy outcome / history (specify): _____</p> <p><input type="checkbox"/> Other current or historical conditions (specify): _____</p>	<p>PLEASE LIST ANY CURRENT MEDICATIONS / SUPPLEMENTS PRESCRIBED:</p> <p>IMPRESSIONS/COMMENTS:</p> 				
<p>LOCAL WIC AGENCY</p>	<table border="1" style="width: 100%; border-collapse: collapse;"> <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> <tr> <td colspan="2" style="padding: 5px;"> <p>IMPORTANT: Must be signed by health care provider Date _____</p> </td> </tr> </table>	Name of physician/health care provider/group/clinic	Telephone number	<p>IMPORTANT: Must be signed by health care provider Date _____</p>	
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