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)

WOMAN'S CURRENT (After Delivery)

Height ______ ins.

Weight ______ lbs.

______ Measurement date

Hemoglobin ______ gm/dl.
and/or
Hematocrit ______ %

______ Blood test date

PREGNANCY OUTCOME

	Full-term	Preterm (37 wks.)	Sm. Gest. Age	Fetal Loss	Stillbirth
1.	☐	☐	☐	☐	☐
2.	☐	☐	☐	☐	☐

Delivery date ______

______ Sex ______ Birth weight ______ Birth length

______ Sex ______ Birth weight ______ Birth length

Please describe any medical conditions affecting the infant(s):

PLEASE INDICATE ANY MEDICAL CONDITIONS AFFECTING THIS WOMAN.

☐ C-Section
☐ Diabetes
☐ Hypertension
☐ Tuberculosis

______ +PPD ______ INH

☐ Other conditions occurring during this pregnancy for delivery (specify):

☐ Other current or historical medical conditions (specify):

PLEASE LIST ANY CURRENT MEDICATIONS/SUPPLEMENTS PRESCRIBED:

IMPRESSIONS/COMMENTS:

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

IMPORTANT: Must be signed by health care provider | Date

LOCAL WIC AGENCY

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