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

Delivery date _____

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

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

PLEASE INDICATE ANY MEDICAL CONDITIONS AFFECTING THIS WOMAN.

- ☐ C-Section
- ☐ Diabetes
- ☐ Hypertension
- ☐ Tuberculosis
- ☐ Other conditions occurring during this pregnancy for delivery (specify):
- ☐ Other current or historical medical conditions (specify):

_____ +PPD _____ INH

LOCAL WIC AGENCY

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

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CDPH 247B Rev 04/17 I #930028

CALIFORNIA WIC WOMEN, INFANTS & CHILDREN

PRINT FORM RESET FORM