State of California—Health and Human Services Agency

California Department of Public Health
California WIC Program

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

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			
1.	☐	☐	☐	☐	☐	____ Sex	____ Birth weight	____ Birth length
2.	☐	☐	☐	☐	☐	____ 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
- ☐ Other conditions occurring during this pregnancy or delivery (specify): ____________________
- ☐ Other current or historical medical conditions (specify): ____________________

_____+PPD _____INH

PLEASE LIST ANY CURRENT MEDICATIONS/SUPPLEMENTS PRESCRIBED:

____

IMPRESSIONS/COMMENTS:

____

LOCAL WIC AGENCY

Name of physician/health care provider/group/clinic

Telephone number:

IMPORTANT: Must be signed by health care provider   Date

In accordance with Federal Law and U.S. Department of Agriculture policy, this institution is prohibited from discriminating on the basis of race, color, national origin, sex, age, or disability. To file a complaint of discrimination, write USDA, Director, Office of Adjudication, 1400 Independence Avenue, SW, Washington, D.C. 20250-9410 or call toll free (866) 632-9992 (Voice). Individuals who are hearing impaired or have speech disabilities may contact USDA through the Federal Relay Service at (800) 877-8339; or (800) 845-6136 (Spanish). USDA is an equal opportunity provider and employer.

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State of California—Health and Human Services Agency

California Department of Public Health
California WIC Program

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)	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):

____

____

- ☐ Other current or historical conditions (specify):

____

PLEASE LIST ANY CURRENT MEDICATIONS / SUPPLEMENTS PRESCRIBED:

____

____

____

IMPRESSIONS / COMMENTS:

____

____

____

LOCAL WIC AGENCY

Butte County WIC - Oroville
82 Table Mountain Blvd
(530) 538-7455 Phone
(530) 538-2092 Fax

Name of physician / health care provider / group / clinic

Telephone Number:

IMPORTANT: Must be signed by health care provider Date

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