

## 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 |
|------------------------------|----------------------------------|------------------|-----------|

| <p><b>WOMAN'S CURRENT</b> (After Delivery)</p> <p>Height _____ ins.      _____ / _____ / _____</p> <p>Weight _____ lbs.      Measurement date</p> <p>Hemoglobin _____ gm/dl.</p> <p>and/or _____ / _____ / _____</p> <p>Hematocrit _____ %      Blood test date</p> | <p style="text-align: center;"><b>PREGNANCY OUTCOME</b></p> <p style="text-align: right;">_____ / _____ / _____<br/>Delivery date</p> <table style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="width: 10%;"></th> <th style="width: 10%;">Full-Term</th> <th style="width: 10%;">Preterm<br/>(37 wks.)</th> <th style="width: 10%;">Sm. Gest.<br/>Age</th> <th style="width: 10%;">Fetal<br/>Loss</th> <th style="width: 10%;">Stillbirth</th> <th style="width: 10%;"></th> <th style="width: 10%;">Sex</th> <th style="width: 10%;">Birth weight</th> <th style="width: 10%;">Birth length</th> </tr> </thead> <tbody> <tr> <td>1.</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td></td> <td style="text-align: center;">_____</td> <td style="text-align: center;">_____</td> <td style="text-align: center;">_____</td> </tr> <tr> <td>2.</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td></td> <td style="text-align: center;">_____</td> <td style="text-align: center;">_____</td> <td style="text-align: center;">_____</td> </tr> </tbody> </table> <p>Please describe any medical conditions affecting the infant(s): _____</p> |                          | Full-Term                | Preterm<br>(37 wks.)     | Sm. Gest.<br>Age         | Fetal<br>Loss | Stillbirth |              | Sex          | Birth weight | Birth length | 1. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |  | _____ | _____ | _____ | 2. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |  | _____ | _____ | _____ |
|---|--|--------------------------|--------------------------|--------------------------|--------------------------|---------------|------------|--------------|--------------|--------------|--------------|----|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--|-------|-------|-------|----|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--|-------|-------|-------|
|   | Full-Term  | Preterm<br>(37 wks.)     | Sm. Gest.<br>Age         | Fetal<br>Loss            | Stillbirth               |               | Sex        | Birth weight | Birth length |              |              |    |                          |                          |                          |                          |                          |  |       |       |       |    |                          |                          |                          |                          |                          |  |       |       |       |
| 1.  | <input type="checkbox"/>   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |               | _____      | _____        | _____        |              |              |    |                          |                          |                          |                          |                          |  |       |       |       |    |                          |                          |                          |                          |                          |  |       |       |       |
| 2.  | <input type="checkbox"/>   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |               | _____      | _____        | _____        |              |              |    |                          |                          |                          |                          |                          |  |       |       |       |    |                          |                          |                          |                          |                          |  |       |       |       |

**PLEASE INDICATE ANY MEDICAL CONDITIONS AFFECTING THIS WOMAN.**

C-Section       Other conditions occurring during this pregnancy or delivery

Diabetes      (specify): \_\_\_\_\_

Hypertension      \_\_\_\_\_

Tuberculosis       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

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