

WIC REFERRAL FOR POSTPARTUM / BREASTFEEDING WOMAN

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