

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)
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WOMAN'S CURRENT (After Delivery) Height _____ ins. Weight _____ lbs. Measurement date _____ Hemoglobin _____ gm/dl. and/or _____ Hematocrit _____ % Blood test date _____	<table style="width: 100%; border-collapse: collapse;"> <tr> <th colspan="5" style="text-align: center; border-bottom: 1px solid black;">PREGNANCY OUTCOME</th> <th style="text-align: right; border-bottom: 1px solid black;">Delivery date _____</th> </tr> <tr> <th style="text-align: center; border-bottom: 1px solid black;">Full-term</th> <th style="text-align: center; border-bottom: 1px solid black;">Preterm (37 wks.)</th> <th style="text-align: center; border-bottom: 1px solid black;">Sm. Gest. Age</th> <th style="text-align: center; border-bottom: 1px solid black;">Fetal Loss</th> <th style="text-align: center; border-bottom: 1px solid black;">Stillbirth</th> <th style="border-bottom: 1px solid black;"></th> </tr> <tr> <td style="text-align: center;">1. <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 style="text-align: center; border-bottom: 1px solid black;">Sex</td> </tr> <tr> <td style="text-align: center;">2. <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 style="text-align: center; border-bottom: 1px solid black;">Birth weight</td> </tr> <tr> <td colspan="5" style="border-bottom: 1px solid black;">Please describe any medical conditions affecting the infant(s):</td> <td style="text-align: center; border-bottom: 1px solid black;">Birth length</td> </tr> <tr> <td colspan="5"></td> <td style="text-align: center; border-bottom: 1px solid black;">Sex</td> </tr> <tr> <td colspan="5"></td> <td style="text-align: center; border-bottom: 1px solid black;">Birth weight</td> </tr> <tr> <td colspan="5"></td> <td style="text-align: center; border-bottom: 1px solid black;">Birth length</td> </tr> </table>	PREGNANCY OUTCOME					Delivery date _____	Full-term	Preterm (37 wks.)	Sm. Gest. Age	Fetal Loss	Stillbirth		1. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Sex	2. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Birth weight	Please describe any medical conditions affecting the infant(s):					Birth length						Sex						Birth weight						Birth length
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PLEASE INDICATE ANY MEDICAL CONDITIONS AFFECTING THIS WOMAN. <input type="checkbox"/> C-Section <input type="checkbox"/> Other conditions occurring during this pregnancy for delivery (specify): <input type="checkbox"/> Diabetes <input type="checkbox"/> Hypertension <input type="checkbox"/> Other current or historical medical conditions (specify): <input type="checkbox"/> Tuberculosis _____ +PPD _____ INH	PLEASE LIST ANY CURRENT MEDICATIONS/SUPPLEMENTS PRESCRIBED: IMPRESSIONS/COMMENTS: <table style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 80%; padding: 5px; border-bottom: 1px solid black;">Name of physician/health care provider/group/clinic</td> <td style="width: 20%; padding: 5px; border-bottom: 1px solid black;">Telephone number:</td> </tr> <tr> <td colspan="2" style="padding: 5px;"> IMPORTANT: Must be signed by health care provider </td> </tr> <tr> <td colspan="2" style="padding: 5px;"> Date </td> </tr> </table>	Name of physician/health care provider/group/clinic	Telephone number:	IMPORTANT: Must be signed by health care provider		Date	
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Date							
LOCAL WIC AGENCY							

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