# 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 | Sex | Birth weight | Birth length |
|---|---|---|---|---|---|---|---|---|
| 1. | ❒ | ❒ | ❒ | ❒ | ❒ | | | |
| 2. | ❒ | ❒ | ❒ | ❒ | ❒ | | | |

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

| Sex | Birth weight | Birth length |
|---|---|---|
| | | |

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

❒ C-Section
❒ Diabetes
❒ Hypertension
❒ Tuberculosis
_____+PPD _____INH

❒ Other conditions occurring during this pregnancy or delivery (specify): _____

❒ Other current or historical medical conditions (specify): _____

**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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