

## 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
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**WOMAN'S CURRENT (PRENATAL)**

Height _____ ins. _____ / _____ / _____ <small>Measurement date</small>	Hemoglobin _____ gm/dl. _____ / _____ / _____ <small>and / or Blood test date</small>	Est. date confinement _____ / _____ / _____ Date last preg. ended _____ / _____ / _____ Gravida _____ Para _____ Pregravid weight _____ lbs.
Weight _____ lbs.	Hematocrit _____ %	

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

- Diabetes
  - Hypertension
  - Previous poor pregnancy outcome / history (specify):  
\_\_\_\_\_
  - Other current or historical conditions (specify):  
\_\_\_\_\_
- Multiple Pregnancy
  - Tuberculosis \_\_\_\_\_+PPD \_\_\_\_\_INH

**PLEASE LIST ANY CURRENT MEDICATIONS / SUPPLEMENTS PRESCRIBED:**

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**IMPRESSIONS / COMMENTS:**

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**LOCAL WIC AGENCY**

Name of physician / health care provider / group / clinic	
Telephone Number:	
<b>IMPORTANT:</b> Must be signed by health care provider	Date

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