

WIC REFERRAL FOR PREGNANT 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)	Telephone Number	Birthdate
WOMAN'S CURRENT (PRENATAL)			
Height _____ ins.	Hemoglobin _____ gm/dl.	Est. date confinement _____/_____/_____	
Measurement date _____/_____/_____	and/or _____	Date last preg. ended _____/_____/_____	
Weight _____ lbs.	Hematocrit _____ %	Gravida _____	Para _____
Pregravid weight _____ lbs.			
<p>PLEASE INDICATE ANY MEDICAL CONDITIONS AFFECTING THIS WOMAN:</p> <p><input type="checkbox"/> Diabetes <input type="checkbox"/> Multiple Pregnancy</p> <p><input type="checkbox"/> Hypertension <input type="checkbox"/> Tuberculosis ___+PPD ___INH</p> <p><input type="checkbox"/> Previous poor pregnancy outcome/history (specify)</p> <p>_____</p> <p>_____</p> <p><input type="checkbox"/> Other current or historical conditions (specify):</p> <p>_____</p> <p>_____</p>	<p>PLEASE LIST ANY CURRENT MEDICATIONS/SUPPLEMENTS PRESCRIBED:</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>IMPRESSIONS/COMMENTS:</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p>		
<p>LOCAL WIC AGENCY</p> <p style="font-size: 1.2em; font-weight: bold;">Riverside County WIC Program</p> <p style="font-size: 1.2em; font-weight: bold;">1.800.455.4942</p>		<p>Name of Physician/Health Care Provider/Group/Clinic</p> <p>_____</p> <p>Telephone Number: _____</p> <p>IMPORTANT: Must be signed by health care provider Date</p>	

✂ Cut on line and submit above form. ✂ Cut on line and submit above form. ✂ Cut on line and submit above form.

Instructions for filling out the WIC Referral for Pregnant Women Form:

1. Height and Weight information should be obtained within sixty (60) days of WIC appointment.
2. Hematocrit or hemoglobin values should be obtained during pregnancy.
3. The form must have the Physician, Health Care Provider, Group, or "Clinic. address stamped on it and be signed by the Health Care Provider.