State of California—Health and Welfare Agency

Department of Health Services
WIC Supplemental Nutrition Branch

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)	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	Birthweight	Birthlength
1.	☐	☐	☐	☐	☐	____	____	____
2.	☐	☐	☐	☐	☐	____	____	____

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

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

Riverside County WIC Program
1.800.455.4942

Name of Physician/Health Care Provider/Group/Clinic

Telephone Number:

IMPORTANT: Must be signed by health care provider Date

PM 247 (1/96)

✂ 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 Postparturn/Breastfeeding 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 after the end of 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.