State of California—Health and Human Services Agency

California Department of Public Health
California WIC Program

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

WOMAN'S CURRENT (PRENATAL)

Height _____ins. _____ /_____ /_____ Measurement date

Weight _____lbs.

Hemoglobin _____gm/dl. _____ /_____ /_____ Blood test date

and / or

Hematocrit _____%

Est. date confinement _____ /_____ /_____

Date last preg. ended _____ /_____ /_____

Gravida _____ Para _____

Pregravid weight _____ lbs.

PLEASE INDICATE ANY MEDICAL CONDITIONS AFFECTING THIS WOMAN:

- ❒ Diabetes
- ❒ Multiple Pregnancy
- ❒ Hypertension
- ❒ Tuberculosis ____+PPD ____INH
- ❒ Previous poor pregnancy outcome / history (specify):

_____

_____

- ❒ Other current or historical 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

CDPH

This institution is an equal opportunity provider.

CALIFORNIA WIC WOMEN, INFANTS & CHILDREN

#930028

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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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