CAMINO HEALTH CENTER
WIC PRENATAL REFERRAL

Health Care Provider:
The Women Infants and Children Supplemental Nutrition Program is requesting the following information to assess your patient's health status and to provide appropriate nutritional counseling. Hemoglobin and/or hematocrit levels are required for program participation. Thank you for your assistance.

Patient Name	**Birth Date**	**WIC ID Number**
______________________	____________	______________________

ANTHROPOMETRIC

1st Trimester Data	**Current Data**
Wt: ____________	Wt: ____________
Ht: ____________	Ht: ____________
Measurement date: ________	Measurement date: ________

BIOCHEMICAL

Hemoglobin:________ gm/dl
Hematocrit:________%
Test Date: ____________

CLINICAL

EDD: ____________
Date last preg ended: ________
Gravida: ____________
Para: ____________

CLINICAL/NUTRITIONAL STATUS

Please indicate any medical conditions affecting this patient's nutritional status.

___ Diabetes Mellitus ___ Gestational Diabetes ___ Chronic Hypertension ___ Pregnancy Induced Hypertension ___ Food Allergies

___ Tuberculosis ___ Multiple Pregnancy ___ Previous history of: ___ Preterm ___ SGA ___LGA ___ other

Other (describe) ____

Is this patient receiving Medical Nutrition Therapy for any of the above conditions? ______________________

Is this patient currently taking any medications that would affect their nutritional status? ______________________

Camino Health Center's WIC Program
San Juan Capistrano Office
Ph: 949-488-7688 Fax: 949-488-7698
Lake Forest Office
Ph: 949-488-7688 Fax: 949-429-7605

Important: Form must be signed by a Heath Care Provider

____
Name of Health Care Provider

____________ ____________
Date Phone Number

The USDA is an equal opportunity provider and employer.

CAMINO HEALTH CENTER
WIC POSTPARTUM REFERRAL

Health Care Provider:
The Women Infants and Children Supplemental Nutrition Program is requesting the following information to assess your patient's health status and to provide appropriate nutritional counseling. Hemoglobin and/or hematocrit levels are required for program participation. Thank you for your assistance.

Patient Name	**Birth Date**	**WIC ID Number**
______________________	____________	______________________

ANTHROPOMETRIC

Current Data

Wt: ____________
Ht: ____________
Measurement date: ________

BIOCHEMICAL

Hemoglobin:________ gm/dl
Hematocrit:________%
Test Date: ____________

PREGNANCY OUTCOME

Date of Delivery: ________
Status of Delivery:

	Sex	Birth wt	Birth length	Full Term	Preterm (<37wks)	SGA	LGA	Fetal Loss	Stillbirth
Infant 1:	____	______	______	☐	☐	☐	☐	☐	☐
Infant 2:	____	______	______	☐	☐	☐	☐	☐	☐

CLINICAL/NUTRITIONAL STATUS

Please indicate any medical conditions affecting this patient's nutritional status.

___ C-Section ___ Diabetes Mellitus ___ Chronic Hypertension ___ Food Allergies ___Tuberculosis

___ Previous history of: ___ Preterm ___ SGA ___LGA ___ other

___ Other (describe): ____

Is this patient receiving Medical Nutrition Therapy for any of the above conditions? ______________________

Is this patient currently taking any medications that would affect their nutritional status or ability to nurse? ______________

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Name of Health Care Provider

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Date Phone Number

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