## CAMINO HEALTH CENTER WIC PRENATAL REFERRAL

The Women Infants and Children Supplemental Nutrition Program is requesting the following information to assess your patient's health status and to provide

Health Care Provider:

Patient Name	th Date	WIC ID Number						
ANTH		BIOCHEMICAL		<u>CLINICAL</u>				
1 <sup>st</sup> Trimester Data	Curre	nt Data	Hemoglobin:	gm/dl	EDD:			
Wt:	Wt:		Hematocrit:	%	Date last preg ended:			
Ht:					Gravida:			
Measurement date:	Measurement da	ate:			Para:			
			RITIONAL STATUS		•			
		_ спольстурени	ension Pregnal	псу ппийсей п	ypertension Food Allergies			
Tuberculosis Mi Other (describe) Is this patient receiving Medica Is this patient currently taking	ultiple Pregnancy 	_ Previous history	v of: Preterm ve conditions?	_ SGALC				
Tuberculosis Mu Other (describe) Is this patient receiving Medica	ultiple Pregnancy al Nutrition Therapy for any medications that	_ Previous history or any of the abov would affect thei	v of: Preterm ve conditions?	_ SGALC	GA other			
Tuberculosis Mu Other (describe) Is this patient receiving Medica Is this patient currently taking Camino Health Center' San Juan Capistra	ultiple Pregnancy al Nutrition Therapy fo any medications that s WIC Program ano Office	_ Previous history or any of the abov would affect their Important: For	v of: Preterm ve conditions? r nutritional status? _ m must be signed by a	_ SGALC	GA other			
Tuberculosis Mu Other (describe) Is this patient receiving Medica Is this patient currently taking Camino Health Center'	ultiple Pregnancy al Nutrition Therapy for any medications that s WIC Program <b>no Office</b> Fax: 949-488-7698	_ Previous history or any of the abov would affect thei	v of: Preterm ve conditions? r nutritional status? _ m must be signed by a	_ SGALC	GA other			

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		Birth Date	WIC ID Nun	iber									
ANTHROPOMETRIC BIOCHEMICAL			PREGNANCY OUTCOME										
Current Data	Hemoglobin:	gm/dl	Date of Deli	very:									
Wt:	Hematocrit:	%	<mark>Status of De</mark>	<mark>livery:</mark>									
Ht:	Test Date:		<mark>Sex</mark>	Birth wt	Birth length	Full Term	Preterm (<37wks)		LGA	Fetal Loss	Stillbirth		
Measurement date:			Infant 1:										
			Infant 2:										
CLINICAL/NUTRITIONAL STATUS													
Please indicate any medical conditions affecting this patient's nutritional status.													
C-SectionDiabetes MellitusChronic HypertensionFood AllergiesTuberculosis													
Previous history of: Preterm SGALGA 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?													
<b>5</b>		<mark>Important: Fo</mark>	it: Form must be signed by a Heath Care Provider										
San Juan Capistrano	Office												
Ph: 949-488-7688 Fax:	949-488-7698	Name of Healt	h Care Provide	r									
Lake Forest Office			<u> </u>										
Ph: 949-488-7688 Fax:	949-429-7605	Date		Phone N	lumber								

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