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? _____

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