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		**BIOCHEMICAL**	**CLINICAL**
1st Trimester Data	**Current Data**		
Wt: _____	Wt: _____	Hemoglobin:_____ gm/dl	EDD: _____
Ht: _____	Ht: _____	Hematocrit:_____%	Date last preg ended: _____
Measurement date: _____	Measurement date: _____	Test Date: _____	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

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