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.

<table>
<thead>
<tr>
<th>Patient Name</th>
<th>Birth Date</th>
<th>WIC ID Number</th>
</tr>
</thead>
</table>

**ANTHROPOMETRIC**

1st Trimester Data | Current Data
--- | ---
Wt: | Wt: |
Ht: | Ht: |
Measurement date: | Measurement date: |

**BIOCHEMICAL**

<table>
<thead>
<tr>
<th>Hemoglobin:</th>
<th>gm/dl</th>
<th>EDD:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hematocrit:</td>
<td>%</td>
<td>Date last preg ended:</td>
</tr>
<tr>
<td>Test Date:</td>
<td></td>
<td>Gravida:</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Para:</td>
</tr>
</tbody>
</table>

**CLINICAL**

<table>
<thead>
<tr>
<th>EDD:</th>
<th>Date last preg ended:</th>
<th>Gravida:</th>
<th>Para:</th>
</tr>
</thead>
</table>

**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?

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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 Health Care Provider**

Name of Health Care Provider

Date | Phone Number
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