



Medical Referral Form for Women and Infants Massachusetts WIC Nutrition Program

Mother's Name: _____ Mother's DOB: _____

Infant's Name: _____ Infant's DOB: _____

HH ID#: _____

I authorize WIC to provide this form to: _____

for completing medical information and returning to the WIC Program. *(Name of Health Center / Hospital / Clinician)*

Applicant / Parent / Guardian's Signature: _____ Date: ____/____/____

STAFF / CLINICIAN: Please complete the section(s) below and sign. WIC eligibility will depend on this information.

FOR PREGNANT WOMEN

EDD ____/____/____ Pregravid weight _____ lb

Current weight _____ lb Height ____ ft ____ in

Date ____/____/____

Date prenatal care began ____/____/____

Gravida _____ Para _____ #TAB _____ #SAB _____

Date of prior delivery / termination, if any: ____/____/____

One blood test required **Date taken:**

HGB _____ gm/dL or ____/____/____

HCT _____ % ____/____/____

For pregnant women, blood must be taken for current pregnancy.

FOR POSTPARTUM WOMEN

Date of delivery / termination ____/____/____

Vaginal _____ C/S _____

Weeks gestation _____ Weight at labor _____ lb

Postpartum weight _____ lb Height ____ ft ____ in

Date ____/____/____

One blood test required **Date taken:**

HGB _____ gm/dL or ____/____/____

HCT _____ % ____/____/____

For postpartum women, blood must be taken after delivery.

FOR INFANTS

Current weight _____ lb _____ oz

Current length _____ in

Date ____/____/____

(must be less than 60 days old on date of WIC appointment)

Birth weight _____ lb _____ oz

Birth length _____ in

Date of first Hep B ____/____/____

Attach immunization records for older infants.

_____/_____/_____
Staff Signature or Stamp Required **Date**

Staff Name *(please print)*

_____-_____-_____
Phone Fax

Please note all that apply:

Woman

- Hypertension Preeclampsia Eclampsia
- Diabetes Gestational diabetes
- Hyperemesis
- Smoking
- Substance use disorder: _____
- Eating disorder: _____
- Chronic asthma
- Iron deficiency anemia
- Intellectual disability
- Depression or other mental health concerns, specify: _____

Please refer to Breastfeeding Support Services

Infant Feeding Comments: _____

Woman Infant

- Infectious disease: _____
- Congenital anomaly: _____
- Food allergy or intolerance: _____
- Rx medication(s): _____
- Other medical concerns: _____

- Prenatal substance exposure
- Please send a copy of the WIC assessment.

For more information, please call WIC at **1-800-WIC-1007**.
You can download many of WIC's forms online at **www.mass.gov/wic**
This institution is an equal opportunity provider.

