

**DEPARTMENT OF HEALTH AND HOSPITALS – OFFICE OF PUBLIC HEALTH  
WOMAN'S  
REFERRAL FOR WIC CERTIFICATION AND INFORMATION TRANSFER FORM**

This information will be used to assist in determining nutrition risk when your patient applies for WIC benefits. Completing this form does not constitute eligibility for the program.

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Date medical information collected: \_\_\_\_\_ (may not be more than 60 days old)

Height \_\_\_\_ ft \_\_\_\_ in \_\_\_\_ /8                      Prepregnancy Weight \_\_\_\_\_ lbs \_\_\_\_\_ /4

LMP Date: \_\_\_\_\_                      Current Weight \_\_\_\_\_ lbs \_\_\_\_\_ /4

EDC Date: \_\_\_\_\_                      Current Hgb \_\_\_\_\_ or Hct \_\_\_\_\_ %

Delivery Date: \_\_\_\_\_                      Lowest Pregnancy Hgb \_\_\_\_\_ or Hct \_\_\_\_\_ %

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\_\_\_\_\_ This patient receives routine prenatal or postnatal care through my medical practice.

\_\_\_\_\_ This patient receives acute and/or specialized health care through my medical practice.

**List pertinent conditions or diagnoses:**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Indicate nutrition problem(s) to be addressed if applicable:** \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

Date: \_\_\_\_\_

\_\_\_\_\_  
**Physician, Nurse, or Nutritionist's Signature and Title**

\_\_\_\_\_  
**Address**

\_\_\_\_\_  
**Telephone Number**

\_\_\_\_\_  
**Fax Number**