



UNFHCC - ERIE COUNTY WIC PROGRAM

WIC MEDICAL REFERRAL ASSESSMENT FORM
BREASTFEEDING AND POSTPARTUM WOMEN

I. GENERAL INFORMATION:

FAMILY ID# _____

Name _____ DOB ____ / ____ / ____

Address _____ Apt # _____

City/Town _____ ZIP _____ Telephone _____

NEW _____ RECERT _____
CLINIC NUMBER 18- _____
FORM DUE BY _____

To certify you must bring the following to your appointment:

- The person being certified
- Proof of income for the entire household
- Proof of your current address
- Identification

II. MEDICAL PROVIDER USE ONLY ALL information ONLY VALID for 30 days

Measurements and blood test results must be filled in by a health care professional, i.e. Doctor, PA, CRNP, Nurse, Medical Records Clerk.

Measurement Date: _____ Present Weight: _____ Present Height: _____

Weight just before delivery _____ Delivery Date: _____

Blood Test Date (post-partum): ____ / ____ Hgb _____ or HCT _____
(If miscarried, enter date)

Signature/Title: _____ Date _____

Please list any special needs for treatments or pregnancy-induced conditions (Medical, Health, or Nutrition related problems) which may be considered in determining applicant's eligibility.

III. WIC OFFICE USE ONLY

Nutrition Risk Identification:

RISK	DOCUMENTATION
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Booker T. Washington Center 1720 Holland St. (814) 453-5747 FAX 456-8865	Mini Mall WIC Office 556 West 4 th St. (814) 459-1948 FAX 459-5220	John F. Kennedy Center 2021 East 20 th St. (814) 899-1734 FAX 899-1679	Girard WIC Office 139 East Main St. (814) 774-8787 FAX 774-5410	MHEDS 2928 Peach St. (814) 453-6229 FAX 456-3731	Union City Hospital 130 North Main St. (814) 438-9207 FAX 438-7613
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