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

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 length _____in
Date ____/____/____
(must be less than 60 days old on date of WIC appointment)

Birth weight _____ lb _____ oz length _____ in

WIC staff helps keep infants and children up-to-date with immunizations by reviewing their status in the Massachusetts Immunization Information System (MIIS).

_____ ____/____/____
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.

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