Referral Form – Pregnant, Postpartum, Breastfeeding Women

Name: _____ Birth Date: _____

Consent
I authorize the release of all medical information to the WIC Program.

Patient Signature: _____ Date: _____

Medical Information Requested

Expected Delivery Date _____ **Hgb/Hct** _____ **Date of Hgb/Hct** _____

Medical Conditions: _____
_____

Problems During Past Pregnancies (not including current)**:**
_____
_____

Current Pregnancy Information Requested

Pregnancy Concerns:

- ☐ Nausea
- ☐ Vomiting
- ☐ Constipation
- ☐ Gestational Diabetes
- ☐ Low Weight Gain
- ☐ Other: _____

Problem During This Pregnancy: _____
_____

Multiple Gestation: Yes _____ No _____ **If yes, how many?** _____

Anticipated or Actual C-Section? Yes _____ No _____

Additional Information: _____

Medical Provider:

_____ _____
Signature Date

_____ _____
Printed Name/Title Telephone

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