

# Pennsylvania WIC Women's Health Referral Form



Send completed forms to:

Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

<b>Patient is:</b> <input type="checkbox"/> Pregnant <input type="checkbox"/> Postpartum - Breastfeeding <input type="checkbox"/> Postpartum - Not Breastfeeding	<b>Ethnicity:</b> <input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino
<b>Race (Check all that apply):</b> <input type="checkbox"/> American Indian/Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black <input type="checkbox"/> Native Hawaiian/Pacific Islander <input type="checkbox"/> White	

Street Address: \_\_\_\_\_ City: \_\_\_\_\_

Zip Code: \_\_\_\_\_ County: \_\_\_\_\_

Phone Number: \_\_\_\_\_ E-mail: \_\_\_\_\_

Anthropometric Measurements	Current Bloodwork	Birth Information
Pre-Pregnancy weight: _____	Hemoglobin: _____ g/dl	Due Date: _____
Current weight: _____	or	# of Babies Delivered: _____
Current height: _____	Hematocrit: _____ %	If the baby is already born:
Date Measured: _____	Date of Blood Test: _____	DOB: _____
		Delivery Method: _____

Food Allergies/Intolerances: \_\_\_\_\_

Medications/Supplements: \_\_\_\_\_

Medications/Supplements: \_\_\_\_\_

Other Pertinent Medical Information: \_\_\_\_\_

Healthcare Facility Name: \_\_\_\_\_

Phone: \_\_\_\_\_

Signature/Title: \_\_\_\_\_

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