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

Current length __________ in

Date ____/____/____

(must be less than 60 days old on date of WIC appointment)

Birth weight __________ lb ________ oz

Birth length __________ in

Date of first Hep B ____/____/____

Attach immunization records for older infants.

____________________ ____/____/____
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: ____________

____
____

Woman	Infant	
	☐	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**
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