



Referral Form – Pregnant, Postpartum, Breastfeeding Women

Name: _____ Birth Date: _____

<p>Consent I authorize the release of all medical information to the WIC Program.</p> <p>Patient Signature: _____ Date: _____</p>
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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:

- | | |
|---------------------------------------|---|
| <input type="checkbox"/> Nausea | <input type="checkbox"/> Gestational Diabetes |
| <input type="checkbox"/> Vomiting | <input type="checkbox"/> Low Weight Gain |
| <input type="checkbox"/> Constipation | <input type="checkbox"/> 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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