Pennsylvania WIC Women's Health Referral Form

Send completed forms to:

Name: _____ **Date of Birth**: _____

Patient is:	**Ethnicity:**
☐ Pregnant ☐ Postpartum - Breastfeeding ☐Postpartum - Not Breastfeeding	☐ Hispanic or Latino ☐ Not Hispanic or Latino
Race (Check all that apply):	
☐ American Indian/Alaska Native ☐ Asian ☐ Black ☐Native Hawaiian/Pacific Islander ☐ White	

Street Address: _____ **City**: _____

Zip Code: _____ **County**: _____

Phone Number: _____ **E-mail**: _____

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

Food Allergies/Intolerances: _____

Medications/Supplements: _____

Medications/Supplements: _____

Other Pertinent Medical Information: _____

_____

Healthcare Facility Name: _____ **Phone**: _____

Signature/Title: _____ **Date**: _____