



# Medical Referral Form for Women and Infants

## Massachusetts WIC Program

Mother's name: \_\_\_\_\_

Infant's name: \_\_\_\_\_

Infant's DOB: \_\_\_\_\_

**Clinician:** Please complete this section - WIC eligibility will depend on this information.  
Applicant authorization appears on the reverse side of this form.

EDD \_\_\_ / \_\_\_ / \_\_\_ Pregravid weight \_\_\_\_\_ lb  
 Date prenatal care began \_\_\_ / \_\_\_ / \_\_\_  
 Gravida \_\_\_\_\_ Para \_\_\_\_\_ #TAB \_\_\_\_\_ #SAB \_\_\_\_\_  
 Date of prior delivery / termination, if any: \_\_\_ / \_\_\_ / \_\_\_  
 Vaginal \_\_\_\_\_ C/S \_\_\_\_\_  
 Date of delivery / termination \_\_\_ / \_\_\_ / \_\_\_  
 Weeks gestation \_\_\_\_\_ Weight at labor \_\_\_\_\_ lb  
 Postpartum weight \_\_\_\_\_ lbs  
 Date \_\_\_ / \_\_\_ / \_\_\_

**For women and infants >6 months:**

One blood test required	Date taken:
HGB _____ gm	___ / ___ / ___
or	
HCT _____ %	___ / ___ / ___

For pregnant women, blood must be taken for current pregnancy. For postpartum women, blood must be taken after delivery.

**For infant:**

Birth weight \_\_\_\_\_ lb \_\_\_\_\_ oz

Birth length \_\_\_\_\_ in

Current weight _____ lb _____ oz
Current length _____ in
Date ___ / ___ / ___

Update immunization book or attach copy of record or give dates:

	DTaP	Polio	MMR	Hib	Hep B	VZV	PCV 7
First							
Second							
Third							
Fourth							

**Please note all that apply:**

Woman

- Hypertension
- Diabetes/gestational diabetes
- Smoking
- Substance abuse, \_\_\_\_\_
- Eating disorder, \_\_\_\_\_
- Chronic asthma
- Iron deficiency anemia
- Depression / mental illness / retardation
- Please provide breastfeeding support

Woman Infant

- Traumatic injury / burns / surgery
- Infectious disease, \_\_\_\_\_
- Congenital anomaly, \_\_\_\_\_
- Food allergy or intolerance, \_\_\_\_\_
- Rx medication, \_\_\_\_\_
- Other medical concerns: \_\_\_\_\_

signature of clinician \_\_\_\_\_

clinician's name (please print) \_\_\_\_\_

phone \_\_\_\_\_

fax \_\_\_\_\_

date \_\_\_ / \_\_\_ / \_\_\_

health center / hospital \_\_\_\_\_

street \_\_\_\_\_

city \_\_\_\_\_

zip \_\_\_\_\_

Send completed form to:

South Berkshire WIC  
 54 Castle Street  
 Gt. Barrington, MA 01230  
 413-528-0457

