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GUAM WIC PROGRAM REFERRAL FORM
WOMEN

PRECERT # _____

Date of initial request for WIC services: _____ Date of WIC appointment: _____

Lab slip provided: Y N Introductory WIC handout provided: Y N WIC staff initial: _____

A. Applicant's Name: _____ Date of birth: _____

Date referred to WIC: _____ Referred by: _____ Agency: _____

B. Note: All data must be less than 60 days old at WIC appointment date.

PREGNANT WOMEN

Date data taken:	Height in inches:	Weight in pounds and ounces:	Date test:	Hgb or Hot:
EDC:	Pre-pregnant weight:	Date Last Pregnancy Ended:		

POSTPARTUM WOMEN

Date data taken:	Height in inches:	Weight in pounds and ounces:	Date test:	Hab. or Hot:
Date last pregnancy ended:	Number previous pregnancies:		Number of live births:	
INFANT:(this pregnancy only)				

Date of delivery:	Number of infants:	Birth weight:	Birth length:	sex:	Infant condition:
	1			M or F	normal defect stillborn
	2			M or F	normal defect stillborn
	3			M or F	normal defect stillborn

C. DIAGNOSED NUTRITION RELATED HEALTH PROBLEMS:

- ____ Anemia
- ____ Nutrient Deficiency Disease (specify) _____
- ____ Gastrointestinal Disorder (specify) _____
- ____ Diabetes mellitus
- ____ Gestational Diabetes
- ____ Thyroid Disorder (specify) _____
- ____ Chronic Hypertension
- ____ Renal Disease (not infections)(specify) _____
- ____ Cancer (specify) _____
- ____ CNS Disorders (specify) _____
- ____ Genetic or Congenital Disorders (specify) _____
- ____ HIV or AIDS
- ____ Recent Major Surgery (specify) _____
- ____ Food Allergy (specify) _____
- ____ Lactose Intolerance (specify extent) _____
- ____ History of Preterm Delivery (dates) _____
- ____ History of Low Birth weight infant (dates) _____
- ____ History of Infant Birth with Defect (specify) _____
- ____ Multi fetal gestation - most recent pregnancy
- ____ Fetal Growth restriction
- ____ Pica (specify) _____
- ____ Maternal Depression (specify) _____
- ____ Alcohol or Illegal Drug use (specify) _____
- ____ Smoking (specify amount) _____
- ____ Other Nutrition Related Health Problem (specify) _____

Signature of referring medical professional:

_____ Date: _____