WIC Medical Referral Form for Women and Infants
Massachusetts WIC Nutrition Program

Mother's Name:_____ **Infant's Name:**_____
Infant's DOB:_____

Clinician: Please complete this section – WIC eligibility will depend on this information.

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 Height __:ft. __:in.
Date:

For women and infants > 9 months
One blood test required

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

For infant
Birth weight ___:lb __:oz
Birth length ___ :in
Current weight: ___ :lb __:oz
Current length: ___ :in
Date:

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:
[ ]	[ ]	Please send a copy of the WIC assessment

_____
signature of clinician

_____ _____
clinician's name (please print) Date

Greater Roslindale Medical & Dental Center
Health Center / Hospital

4199 Washington Street, Suite #1
Street

617 - 323 - 4440 phone
617- 323 - 7870 fax
Roslindale city
02131 zip

Send completed form to: ROSLINDALE WIC PROGRAM ROSLINDALE (617) 323-4649
4258 WASHINGTON STREET
ROSLINDALE MA 02131