State of Connecticut-Department of Public Health-WIC Program
CERTIFICATION/MEDICAL REFERRAL FORM for WOMEN

Participant ID #: _____ Family ID #: _____

Name: _____ **Date of Birth (DOB)** _____/____/_____

Address: _____ **Phone:** (_____)_____

☐ **Pregnant: _____ weeks**	**Pre-pregnancy weight:**	*__Trimesters 1 & 3: Hgb < 11.0 g/dl; Hct: <33%__
EDD:	**DATE COLLECTED (Wt/Ht):**	**Trimester 2: Hgb < 10.5 g/dl; Hct: <32%**
☐ **Postpartum**	**Weight: Height:**	**Non-preg <15 yrs: Hgb < 11.8 g/dl; Hct: <33.7%**
☐ **Breastfeeding**	**DATE COLLECTED (Hgb/Hct):**	**Non-preg 15-17 yrs: Hgb < 12.0 g/dl; Hct: <35.9%**
Actual delivery date:	**Hemoglobin: & /or Hematocrit:**	**Non-preg >18 yrs: Hgb < 12.0 g/dl; Hct: <35.7%**
Medications/Medical Problems/Concerns:		

Weight/height measurements must be within 60 days of WIC certification appointment.

ANTHROPOMETRIC
1. ☐ Pre-pregnancy or postpartum underweight (Body Mass Index-BMI <18.5) _____ **BMI**
2. ☐ Pre-pregnancy or postpartum overweight (BMI ≥ 25) _____ **BMI**
3. ☐ Low maternal weight gain _____ or weight loss _____ during pregnancy
4. ☐ High maternal weight gain

BIOCHEMICAL (1998 CDC Standards)
5. ☐ Anemia*
6. ☐ Elevated blood lead level (≥ 5 ug/dl in last 12 months)

CLINICAL/ HEALTH/ MEDICAL
7. ☐ Nutrient deficiency disease. Specify_____
8. ☐ Gastrointestinal disorder. Specify _____
9. ☐ Nutritionally significant genetic or congenital disorder. Specify_____
10. ☐ Nutrition related infectious disease. ☐ Acute ☐ Chronic Specify _____
11. ☐ Nutrition related non-infectious chronic disease. Specify _____ ____/____ mm Hg
12. ☐ Other nutrition related medical conditions. Specify _____
13. ☐ Tobacco or nicotine use by a pregnant, breastfeeding or postpartum woman.
14. ☐ Alcohol use ☐ or substance use (includes prescription drug abuse) ☐ Specify. _____
15. ☐ Oral health conditions. Specify _____

OBSTETRICAL:
16. ☐ Hyperemesis gravidarium
17. ☐ Gestational diabetes: presence of ☐; history of ☐
18. ☐ History of diagnosed Preeclampsia (pregnancy-induced hypertension) ____/_____ mm Hg (>140mm Hg systolic or > 90mm Hg diastolic)
19. ☐ History of preterm (≤ 36 6/7 weeks); or early term (≥ 37 0/7 weeks and ≤ 38 6/7 weeks gestation) delivery
20. ☐ History of low birth weight (< 5.5 pounds or < 2500 grams) delivery
21. ☐ History of spontaneous abortion (≥ 2), fetal or neonatal death
22. ☐ Pregnancy at a young age ≤ 20 years _____
23. ☐ Short Interpregnancy interval (<18 months between live births)
24. ☐ Prenatal care beginning after the first trimester
25. ☐ Multifetal gestation
26. ☐ Fetal Growth Restriction (FGR) (fetal weight < 10th percentile for gestational age)
27. ☐ History of birth of a large for gestational age infant (≥ 9 pounds or ≥ 4000 grams)
28. ☐ History of birth with nutrition-related congenital or birth defect
29. ☐ Pregnant woman currently breastfeeding
30. ☐ Breastfeeding mother of infant at nutritional risk ☐ non-dietary; ☐ dietary
31. ☐ Breastfeeding complications or potential complications. Specify_____

DIETARY (Document in CT-WIC)
32. ☐ Specify code(s)

_____

OTHER NUTRITIONAL RISKS
33. ☐ Possible regression in nutritional status if removed from the program ☐ non-dietary; ☐ dietary
34. ☐ Homelessness or migrancy
35. ☐ Other risks. Specify _____

Health Care Provider Signature and Title: _____**Date:** _____

Address: _____

Signature/Initials of WIC CPA _____**WIC Certification Date:** _____

Applicant/Participant Authorization/Autorización del solicitante/participante:

I, Yo, _____ give permission to/ doy mi permiso a:
(Print Name/ Nombre en letra de imprenta)

Date/ Fecha ____/____/_____ _____
(Health Care Provider or Organization/ Proveedor de atención de la salud u organización)

Date/ Fecha ____/____/_____ _____
(Health Care Provider or Organization/ Proveedor de atención de la salud u organización)

to release my health information, listed on the other side of this WIC certification form to the WIC Program, my health care provider and/or the organization listed above for WIC staff to determine if I qualify for the WIC Program and to coordinate WIC nutrition services for my benefit. I also agree WIC staff may talk with my health care provider and/or the organization listed above about any medical/behavioral concerns that may affect my overall health in order to better coordinate my care.

para divulgar mi información de salud—la cual se encuentra en el reverso de este formulario de certificación del Programa WIC, para que el personal del Programa WIC determine si yo soy elegible para el WIC y para coordinar los servicios de nutrición que el WIC me brindará. También acepto que es posible que el personal del WIC se comunique con mi proveedor de atención de la salud o la organización indicada anteriormente sobre toda inquietud médica o del comportamiento que pueda afectar mi salud general para una mejor coordinación de mi cuidado de salud.

- I understand that I do not have to give my health care provider or organization permission to share information about me with the WIC Program. If I choose not to give this permission, in order to receive WIC nutrition services and benefits, I will need to give WIC permission directly to take my height and weight at the WIC office.

- Comprendo que no tengo que dar permiso a mi proveedor de atención de la salud o ninguna organización para compartir mi información con el Programa WIC. Si decido no dar autorización, para poder recibir servicios y beneficios, necesitaré dar permiso directamente al Programa WIC para que tome mi peso y estatura en la oficina WIC.

- I understand that I can change my mind and cancel this permission at any time. To do this, I need to write a letter to my provider or organization and send it or take it to where I am now giving permission. ☐ Permission cancelled
  Date: ____/____/_____

- Comprendo que puedo cambiar de idea y cancelar esta autorización en cualquier momento.
  Para hacerlo, debo escribir una carta a mi proveedor de atención de la salud o la organización indicada anteriormente y enviarla o llevarla al lugar donde ahora estoy dando mi permiso. ☐ El permiso cancelado **Fecha:** ____/____/_____

Authorized Signature/ Firma del representante autorizado: _____

Relationship to Participant/Relación con el participante: _____ **Date/Fecha:** ____/_____/_____

This permission is good for 1 year from the date of the authorized signature above.
Este permiso es válido durante un año a partir de la fecha de la firma del representante autorizado precedente.

If the information has already been given out, I understand it is too late for me to change my mind and cancel the permission.
Si mi información ya ha sido proporcionada, comprendo que es demasiado tarde para que cambie de opinión y cancele el permiso.

WIC staff follows Federal law to protect WIC participant privacy (confidentiality) and cannot re-disclose (share) WIC applicant or participant information except with written consent or as required by law.

El personal del WIC sigue las leyes federales para proteger la privacidad (confidencialidad) de los participantes del WIC y no puede revelar (compartir) la información del solicitante o participante del WIC, a menos que cuente con un consentimiento por escrito o según lo requiera la ley.

☐ **Declined** **Date/Fecha** ____/____/_____

This institution is an equal opportunity provider. **Esta institución es un proveedor que ofrece igualdad de oportunidades.**

State of Connecticut-Department of Public Health-WIC Program
CERTIFICATION/MEDICAL REFERRAL FORM for WOMEN
Guidelines for Use

Participant Information and Health Data and Nutrition Risk sections:

Participant and/or Family ID #: To be completed by WIC Program staff.

All other **participant information** fields to be completed by WIC staff- most likely a Program Assistant **or** health care provider's (HCP) office staff- including Participant Name, Date of Birth, Address, Phone # and Health Plan.

Participant Health Data fields are to be completed by the Health Care Provider or the WIC Nutrition staff i.e. Competent Professional Authority (CPA). For Pregnant women: # weeks and EDD. For Breastfeeding or Postpartum women: check appropriate box and indicate actual delivery date. For all categories: weight, length/height, hematological data (with dates), pre-pregnancy weight and medications/medical conditions. Note: Weight/height measurements must be within 60 days of WIC certification appointment. Hemoglobin or hematocrit results must be within the following timeframes: once during pregnancy and once following the pregnancy (birth) for pregnant or postpartum or breastfeeding women as indicated by Federal WIC Regulations.

Health care provider or WIC CPA must check all applicable nutrition risk factors including anthropometric, biochemical, clinical/health/medical/, dietary or other based on medical examination or complete nutrition assessment. Specify condition where indicated. Note: If the WIC CPA has questions or concerns regarding data entered by the health care provider she should follow up as appropriate with health care provider for clarification.

Health Care Provider Signature and Title is required. The health care provider must complete the date and location of practice/clinic/office. By signing this form the HCP verifies he/she has seen and evaluated the patient.

Shaded Gray area: To be completed by WIC CPA. WIC CPA Signature and WIC Certification date is required to certify the information on the Medical Referral Form has been reviewed and verified. HCP checked Nutrition Risk Criteria should be entered into CT-WIC in the relevant Screens. If the form is being used for a mid-certification, check the appropriate box.

- If the participant doesn't present with a HCP completed WIC Certification/Medical Referral Form, the WIC CPA doesn't need to complete a form to process a certification appointment. Simply, use the Guided Script in CT-WIC to complete the WIC certification process, assess and document risks. Although not required for certification, it may be good practice to provide a WIC Certification/Medical Referral Form to participants /caretakers to have their HCP complete, to either verify medical conditions or to ensure continuity of care.

Applicant/Participant Authorization Section:

This section must be completed by all applicants and participants. If applicant or participant declines to allow WIC to share information with health care provider or organization listed, check the box marked, declined. WIC staff must take anthropometric measurements in the WIC office. See WIC 200-13 for more details on this section.