

STATE OF CONNECTICUT DPH/WIC PROGRAM: Nutrition Services Chart Audit Tool

Local Program Name and Site Conducted: _____

Reviewers Name: _____

Date: _____

Name, Family ID and Participant ID	Category/Priority (PBNIC)	Date of birth/Sex Matches	Processing Standard met	Income Eligibility	Identity/Residency	Physical Presence	Bloodwork	Ht/Wt	Pregnancy Documented	Nutrition Risk Documented	Food Package correct	Nutrition Education Documentation & Contacts (2 in 6 months)	Follow up note	Care plan for high risk	Referral/Follow up	Food Security Assessed & Action Taken	PMAD Screen Completed and Referral(s) Provided	Next App' t Scheduled	CPA Signature and Date	Rx/signed/dated for non-contract formula or FP3	Comments

√ = Correct X = Missing I = Incomplete NA = Not Applicable

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