ALLEGANY COUNTY WIC PROGRAM

3453B Route 417E, Wellsville, NY 14895 585-593-2533 or 1-800-394-1942 Fax 585-593-0392

New Baby Medical Referral Form

IF CURRENTLY ON WIC	IF NOT CURRENTLY ON WIC
Name _____	Name _____
Site _____ ID# _____	Address _____
Phone _____	_____
Appointment Date ___/___/___ Time_____	Phone _____

Before You Have Your Baby…

1) Learn the advantages of breastfeeding. It is an inexpensive and easy way to ensure that your baby is getting the proper amount of nutrients. WIC staff and Peer Counselors are available to answer any questions you may have about breastfeeding at all of your visits. If you do not plan to breastfeed, check the store's current prices and set aside money for formula. It may be one month or more before WIC will be able to enroll your new infant, and NO FORMULA checks will be issued until the baby is enrolled (certified). You may use food stamps to purchase formula.
2) PACK THIS FORM IN YOUR SUITCASE so the medical staff can provide us with the information needed after your delivery. Be sure to sign the authorization for release of information at the top of the other side of this form before giving it to hospital personnel for completion.

At the Hospital…

1) Give this form to the medical staff to complete the reverse side and sign. Please be sure they then return it to you before you leave. Be sure it is completed in full and signed by a doctor or registered nurse.
2) Remember, if your infant is not breastfeeding, and requires a different formula other than our three contract formulas: Enfamil Infant Premium, Gerber Good Start Soy or Enfamil Gentlease, you will need to obtain a doctor's prescription with the reason your baby needs a specialized formula in order for WIC to provide you with checks for the necessary formula.

When You Return Home…

1) If you have been on WIC during your pregnancy, call the WIC office as soon as possible with the information on your completed NEW BABY MEDICAL REFERRAL FORM. Your appointment is not confirmed until you contact us with your delivery information.
2) If you have not been on WIC during your pregnancy, please call the office to answer a few simple questions to determine your eligibility for the WIC Program and receive and appointment. You will be scheduled for the earliest available appointment.
3) Remember when scheduling your next appointment that this will be a certification appointment. Please prepare for your scheduled visit by gathering proof of identification for yourself &your baby (hospital crib card), proof of residency (physical address), and proof of income eligibility (pay stubs for last 30 days for each working member of your household OR Medicaid Benefits cards OR proof of active enrollment in the Food Stamp Program).

I authorize the release of the information below to the WIC Program and I authorized the WIC Program to release this information about me to this Health Care Provider for the purpose of coordinating my health care services. If I need to transfer to another WIC Program, I authorize the release of this information to the transferring WIC Program. All information is considered confidential.

_____

Your Signature *Date*

Mother's Delivery Information

(to be completed by hospital personnel)

Name _____

Date of Delivery _____

Gravida _____ Para _____

Was breastfeeding initiated? **YES** or **NO**

Weight (after delivery) _____ Date Taken ____/____/____

HGB____ or HCT _____(after delivery) Date Taken ____/____/____

Labor/Delivery Complications? (if yes, please specify)

_____

_____

_____

_____

☐ Genetic/Congenital Disorders, Inborn /Thyroid Disorder

(Specify) _____

☐ Nutrient Deficiency/ Disorder

(specify)_____

☐ Gestational Diabetes

☐ Insulin/Noninsulin Dependent Diabetes or Hypoglycemia

(specify) _____

☐ Essential/Chronic Hypertension

☐ Asthma

☐ Recent Major Surgery, **Including C-section**, Trauma, or burns within 6 months

☐ Infectious Diseases (specify) _____

☐ Gastrointestinal Disorders (specify) _____

☐ Food Allergy (ies) (specify) _____

☐ Chronic Medical/Health Conditions/Diseases (specify)

_____

☐ Eating Disorders

☐ Depression

☐ Smoking (# of cigarettes per day) _____

☐ Drug/ Alcohol Abuse (specify) _____

☐ Other (specify) _____

_____

Signature of MD or RN Hospital Name Date

Infant's Delivery Information (to be completed by hospital personnel)

Baby's Full Name _____ **M** or **F** Date of Birth ____/____/____

Birth Weight _____ Birth Length _____ Weeks Gestation _____

Hep B shot given? **Y** or **N** Date given ____/____/____ Medical Problems? (specify) _____

Weight at discharge _____ _____

Feeding (circle one) **Breastfeeding** **Bottle feeding** **Both**

Any problems breastfeeding? **Y** or **N**

(specify) _____

_____

Infant's doctor will be (please print)

_____

☐ Enfamil Premium Infant

☐ Gerber Good Start Soy

☐ Enfamil Gentlease

☐ Other (requires a doctor's prescription) _____

_____

Signature of MD or RN Hospital Name Date