

BREASTFEEDING and POSTPARTUM WOMAN WIC WORKSHEET

Contact Date: _____	<input type="checkbox"/> New Client/New Group
Date Service Provided: _____	<input type="checkbox"/> New Client/Existing Group
	<input type="checkbox"/> Existing Client
Wizard: <input type="checkbox"/> Prescreen <input type="checkbox"/> NC <input type="checkbox"/> CC <input type="checkbox"/> RC <input type="checkbox"/> Other _____	

Demographics

Client Last: _____	Client First: _____	MI: _____	DOB: _____
Caregiver Last: _____	Caregiver First: _____	MI: _____	
Alternate Last: _____	Alternate First: _____	MI: _____	
PHONE: _____	Msg. Phone: _____	Phone Notes: _____	
Address: _____	City: _____	Zip: _____	
<input type="checkbox"/> Homeless	<input type="checkbox"/> Migrant	Language for Interpreter: _____	

Race/Ethnicity

Do you consider yourself Hispanic or Latino?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
How do you describe your race? Choose all that apply.		
<input type="checkbox"/> American Indian or Alaska Native	Tribe: _____	
<input type="checkbox"/> Asian		
<input type="checkbox"/> Black or African American		
<input type="checkbox"/> Native Hawaiian or other Pacific Islander		
<input type="checkbox"/> White		

Income

Number in Household: _____	<input type="checkbox"/> Medicaid	<input type="checkbox"/> TANF	<input type="checkbox"/> Basic Food Program	<input type="checkbox"/> FDPIR
Source: _____	Proof: _____	Income Amount: _____		<input type="checkbox"/> Weekly
				<input type="checkbox"/> Monthly
				<input type="checkbox"/> Yearly
Proof ID: _____	Proof Residency: _____			

Custom Tab

Feeding Status: <input type="checkbox"/> Fully BF	<input type="checkbox"/> Partially BF	<input type="checkbox"/> Some BF 0-6	<input type="checkbox"/> Some BF 7-12
<input type="checkbox"/> Fully BF Multiples	<input type="checkbox"/> Partially BF Multiples	<input type="checkbox"/> Postpartum	
Delivery Date: _____	Medical Provider: _____		

Measures

Date: _____ Height: _____ - _____ /8 Weight: _____ lb. _____ oz. Pre-pregnancy Wt.: _____

Date Taken: _____ Hgb/Hct: _____ Notes _____

Assessment

Risk Factors: _____ Risk Factor Notes: _____
 Or attach Assessment Questions _____

 PDHR High Risk Eligibility Begins: _____

Nutrition Education

Topics	Handouts
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Referrals

Streamlined Basic Contact

WIC Signature Form Rights & Responsibilities
 ID Check Check education
 Appointment folder

Voter Registration: _____

Notes:

Staff: _____ Co-sign: _____

Once information is entered into the computer, please shred this document to protect client information.



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