

HIGH RISK CARE PLAN – INFANT WORKSHEET

Demographics

Client Last: _____ First _____ MI _____ Status: _____

Gender: Female Male DOB: _____

Group Data

Caregiver Last: _____ Caregiver First: _____ MI _____

Alternate Last: _____ Alternate First: _____ MI _____

Phone: _____ Msg.Phone: _____ Phone Notes: _____

Address: _____ City: _____ Zip: _____

County: _____ City County

Mail: _____ City: _____ Zip: _____

BL: ____ in ____ 8ths BW: ____ lb ____ oz Bsfed: currently never stopped: ____ (date)

RD C

Date Service Provided: _____ Provider Type: WIC MSS Other _____

Prof. Interpreter Used Paper Copy Gestational Age: _____

SUBJECTIVE

Medical Provider: _____

Caregiver Concerns: Growth Food Intake Other: _____

Appetite: Good Fair Poor Variable Food Supply: Adequate Inadequate

Familial Growth Patterns _____ Activity Level _____

Family Hx of Food Allergies _____

Psychosocial/Recent Health Concerns _____

OBJECTIVE

Measures

Date: _____ Height: ____ - ____/8 Length: ____ - ____/8 Weight: ____ lb. ____ oz. Head Circ: ____ - ____/8

Date: _____ Height ____ - ____/8 Length: ____ - ____/8 Weight : ____ lb. ____ oz. Head Circ: ____ - ____/8

Date Hct/Hgb Taken: _____ Hct. ____ Hgb. ____ Notes _____

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Meds: _____		Other: _____	
<input type="checkbox"/> Iron	<input type="checkbox"/> Fluoride	<input type="checkbox"/> Vitamins	<input type="checkbox"/> Minerals
Current Feeding:			
<input type="checkbox"/> Breast	<input type="checkbox"/> Formula		

ASSESSMENT

Nutritional Concerns:

PLAN

Client's Goal: _____

Program Goal: _____

Reinforce _____

Receive Instruction On: _____

Recheck: Hct./Hgb. Diet Weight

I: NUTRITION EDUCATION

Date	Topics	Handouts

I: CLIENT REFERRALS

Service	Has	Ref	Has App	NI	Service	Has	Ref	Has App	NI	Other
TANF					Doctor					
Medicaid					Dentist					
Food Stamps					Immunizations					
Child Support Enf.					Family Planning					
Other _____					Other _____					

EVALUATION

NOTES

Food Package: _____ **Food Package Modifications:** _____

Registered Dietitian: _____



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