Rhode Island Department of Health WIC Program

Medical Information Form for Breastfeeding/Postpartum Women

Note to Health Care Provider:
Please print out this form, complete it and give it back to your patient to return to WIC

A. Patient Information
Name:
Date of Birth:
Delivery Date:
Please list all medications **and** supplements prescribed:

B. Delivery Information	
Height:	*Lab Result Date:
Pregravid Weight (PGW):	*Hgb:
Weight at Delivery:	*Hct:
Total Pregnancy Weight Gain:	*Must be collected 4-6 weeks after delivery

C. Most Recent Pregnancy Outcome		
☐ Low Birth Weight Infant	☐ Multiple Births	☐ Gestational Diabetes
☐ Premature Birth	☐ Low Maternal Weight Gain	☐ Preeclampsia
☐ C-Section Delivery	☐ High Maternal Weight Gain	☐ Fetal / Neonatal Loss

D. Other Health/Medical Concerns (Please describe)

E. Breastfeeding Information
☐ Fully breastfeeding
☐ Feeding breastmilk and formula
☐ Never breastfed
☐ Please refer to WIC IBCLC / CLC for assessment
Reason for referral: _____

F. Patient's Health Care Provider	
Provider Name:	
Signature:	Date:
Address:	Phone: