



**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: _____	C-Section: Yes___ No___

B. Delivery Information	
Height:	Date Collected:
Pregravid Weight (PGW):	*Hgb:
Weight at Delivery:	*Hct:
	*Must be collected after delivery

C. Most Recent Pregnancy Outcome	
Preterm Delivery: Yes___ No___	If yes, weeks gestation:
<input type="checkbox"/> LBW	<input type="checkbox"/> Fetal/Neonatal loss
Multiple Births: Yes___ No___	

D. Health/Medical Concerns (including ICD-9 code (s))

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