



**UNFHCC - ERIE COUNTY WIC PROGRAM**  
**WIC MEDICAL REFERRAL ASSESSMENT FORM**  
**PREGNANT WOMEN**

**I. GENERAL INFORMATION:**

FAMILY ID# \_\_\_\_\_

Name \_\_\_\_\_ DOB \_\_\_/\_\_\_/\_\_\_

Address \_\_\_\_\_ Apt. # \_\_\_\_\_

City/Town \_\_\_\_\_ ZIP \_\_\_\_\_ Telephone \_\_\_\_\_

Endorser \_\_\_\_\_

NEW \_\_\_\_\_ RECERT \_\_\_\_\_  
 CLINIC NUMBER 18- \_\_\_\_\_  
**FORM DUE BY** \_\_\_\_\_

**To certify you must bring the following to your appointment:**

- The person to be certified
- Proof of income for the entire household
- Proof of your current address
- Identification

**II. MEDICAL PROVIDER USE ONLY ALL information ONLY VALID for 30 days**

*Measurements and blood test results must be filled in by a health care professional, i.e. Doctor, PA, CRNP, Nurse, Medical Records Clerk.*

Measurement Date: \_\_\_\_\_ Present Weight: \_\_\_\_\_ inches Present Height: \_\_\_\_\_

Pre-pregnancy Weight: \_\_\_\_\_ Expected Delivery Date: \_\_\_\_\_

Blood Test Date: \_\_\_\_\_ Hgb \_\_\_\_\_ or HCT \_\_\_\_\_

Signature/Title: \_\_\_\_\_ Date \_\_\_\_\_

Please list any special needs for treatments or pregnancy-induced conditions (Medical, Health, or Nutrition related problems) which may be considered in determining applicant's eligibility.

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**III. WIC OFFICE USE ONLY**

**Nutrition Risk Identification:**

**RISK                      DOCUMENTATION**

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_____	_____
_____	_____
_____	_____

Booker T. Washington Center 1720 Holland St. (814) 453-5747 FAX 456-8865	Mini Mall WIC Office 556 West 4 <sup>th</sup> St. (814) 459-1948 FAX 459-3063	John F. Kennedy Center 2021 East 20 <sup>th</sup> St. (814) 899-1734 FAX 899-1679	Girard WIC Office 139 East Main St. (814) 774-8787 FAX 774-5410	MHEDS 2928 Peach St. (814) 453-6229 FAX 456-3731	Union City Family Center 38 North Main St. (814) 438-9207 FAX 438-7613
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