



# MAINE CDC WIC NUTRITION PROGRAM Request for Information for WOMEN

Return this form to:

To: \_\_\_\_\_ Fax: \_\_\_\_\_

Client Name: \_\_\_\_\_ DOB: \_\_\_\_\_ WIC Clinic: \_\_\_\_\_

**Please complete the following information, which may be used to determine eligibility for the WIC Nutrition Program**

- EDD \_\_\_\_\_
- Hgb/Hct \_\_\_\_\_ Date Taken \_\_\_\_\_
- Most recent: Height: \_\_\_\_\_ Weight: \_\_\_\_\_ Date Taken: \_\_\_\_\_

**BEDREST:** Participant is on bedrest and is unable to be present at WIC appointments

**Check all current medical conditions that apply:**

<input type="checkbox"/> Depression	<input type="checkbox"/> Persistent Asthma requiring daily medication
<input type="checkbox"/> Multifetal Gestation	<input type="checkbox"/> Preeclampsia
<input type="checkbox"/> Fetal Growth Restriction	<input type="checkbox"/> Hypertension/Prehypertension
<input type="checkbox"/> Diabetes: <input type="checkbox"/> Type 1 <input type="checkbox"/> Type 2 <input type="checkbox"/> Gestational <input type="checkbox"/> Prediabetes	<input type="checkbox"/> Eating Disorder (specify): _____
<input type="checkbox"/> Thyroid Disorder (specify): _____	<input type="checkbox"/> GI Disorder (specify): _____
<input type="checkbox"/> Drug Treatment Program (currently enrolled)	<input type="checkbox"/> Hyperemesis Gravidarum
<input type="checkbox"/> Illicit Drug Use	
<input type="checkbox"/> Other (specify any other conditions which may potentially affect nutrition status):	

**Current Prescribed and OTC Medications:**

**Please verify past medical conditions:**

<input type="checkbox"/> History of Gestational Diabetes	<input type="checkbox"/> History of Miscarriage (date[s]):
<input type="checkbox"/> History of Preeclampsia	<input type="checkbox"/> History of Stillbirth or Neonatal Death

Provider's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

My consent to authorize the release of this information is effective for \_\_\_\_\_ months (not to exceed 12 months).

- The WIC program may request information from my provider about information above.
- I understand that I can cancel this authorization at any time by notifying my local WIC office.
- I am entitled to a copy of this form.

Signed: \_\_\_\_\_ Date: \_\_\_\_\_  
WIC Participant

Signed: \_\_\_\_\_ Date: \_\_\_\_\_  
WIC Program Representative