



Rhode Island Department of Health WIC Program



Medical Information Form for Breastfeeding/Postpartum Women

*The healthcare provider should print out this form, complete it, and give it back to the patient.
The patient should return the completed form to their local WIC agency.*

A. Patient Information		
Name:		
Date of Birth:		
Delivery Date:		
Please list all medications and supplements prescribed:		
B. Delivery Information		
Height:	Lab result date*:	
Pre-gravida weight (PGW):	Hgb*:	
Weight at delivery:	Hct*:	
Total pregnancy weight gain:	<i>*Must be collected 4-6 weeks after delivery</i>	
C. Most Recent Pregnancy Outcome		
<input type="checkbox"/> Low birth weight infant	<input type="checkbox"/> Multiple births	<input type="checkbox"/> Gestational diabetes
<input type="checkbox"/> Premature birth	<input type="checkbox"/> Low maternal weight gain	<input type="checkbox"/> Preeclampsia
<input type="checkbox"/> C-section delivery	<input type="checkbox"/> High maternal weight gain	<input type="checkbox"/> Fetal/Neonatal loss
D. Other Health/Medical Concerns (Please describe.)		
E. Breastfeeding Information		
<input type="checkbox"/> Fully breastfeeding <input type="checkbox"/> Feeding breast milk and formula <input type="checkbox"/> Never breastfed		
<input type="checkbox"/> Refer to WIC IBCLC/CLC for assessment: Reason for referral: _____		
F. Patient's Healthcare Provider		
Provider Name:		
Signature:	Date:	
Address:	Phone:	