1. Last Name First Name MI

2. Patient Number - H

3. Date of Birth Month Day Year

4. Race ❒ 1. White ❒ 2. Black /African American ❒ 3. America Indian/Alaskan Native ❒ 4 Asian ❒ 5. Hawaiian/Other Pacific Islander ❒ 6. Unknown
Ethnicity: Hispanic origin? ❒ Yes ❒ No

5. Sex 1. Male 2. Female

6. County of Residence

Address

Phone:

N.C. Department of Health and Human Services

WIC NUTRITION ASSESSMENT & CARE PLAN INFANTS

❒ **Certification** ❒ **Mid-year assessment**

Client age_____ ❒ Client present

Health Insurance ❒ Medicaid ❒ Other ❒ None

Health care provider _____

Primary caretaker & relationship _____

Primary Language (if other than English)_____

Name of Interpreter (if used): _____

Household composition**:** # Adults # Children

SUBJECTIVE AND OBJECTIVE INFORMATION

Mark boxes that apply and document relevant details. Indicate when information is elsewhere in medical record.

ECO-SOCIAL

Household has**:** ❒ person(s) who smokes ❒ FNS (food stamps) ❒ inadequate water source ❒ food security issues ❒ inadequate appliances to store/cook food

Client is: ❒ in child care ❒ in foster care date:_____ ❒ homeless ❒ a migrant ❒ with primary caretaker with limited abilities ❒ breastfed infant with Priority I or IV mother or at-risk non-WIC mother ❒ mother w/ prenatal drug/alcohol use or mental retardation

❒ No client-reported problem

ANTHRO & BIOCHEMICAL

Birth length _____ Birth weight _____ Weeks gestation _____

Length _____ Weight _____ Date of measures _____

Parental BMI (❒ Mother's OR ❒ Father's) _____

Hemoglobin _____Hematocrit_____Date of test_____ Blood lead_____Date of test_____

CLINICAL

Has**:** ❒ medical condition(s) ❒ oral health condition(s) ❒ breastfeeding complications

Uses**:** ❒ Rx medications ❒ OTC medications ❒ vitamins

stools /24 hours _____ # wet diapers /24 hours _____

Immunization status**:** ❒ up-to-date ❒ not up-to-date ❒ immunization record is unavailable

❒ No client-reported problem

DIET & PHYSICAL ACTIVITY

If breastfeeding**:** # times nursing / 24 hrs _____

If formula feeding**:** name of formula _____ ❒ concentrated ❒ powdered ❒ RTF

ounces formula / feeding _____ # times feeding / 24 hrs _____

Behaviors *(✓ frequency)*	Most days	Some days	Rarely
Has age-appropriate physical activity			
Consumes age-appropriate beverages			
Consumes age-appropriate foods			
Uses age-appropriate feeding skills			
Consumes Vitamin D source			

	Most days	Some days	Rarely
"Watches" TV			
Other / inappropriate nutrition behavior(s)**:**			
_____			
_____			

SUMMARY OF NUTRITION STATUS (includes nutrition problems and/or potential problems)

Name:_____ Date of Birth:_____

***Identify WIC nutrition risk criteria (✓all that apply)*:**

- ❒ B09 At risk of overweight
- ❒ B42 Underweight or at risk of underweight
- ❒ B47 High weight-for-length
- ❒ B12 Short stature or at risk of short stature
- ❒ B65 Inadequate growth (rate of weight gain)
- ❒ B15 Failure to thrive
- ❒ B16 Small for gestational age
- ❒ B17 Low birth weight or very low birth weight
- ❒ B18 Large for gestational age / birth weight ≥9 lbs
- ❒ B22 Low hemoglobin/hematocrit (<11gms/33%)
- ❒ B23 Elevated blood lead (≥ 10ug/dL)
- ❒ B36 Fetal Alcohol Syndrome
- ❒ B37 Premature birth (gestational age ≤ 37 weeks)
- ❒ B87 Breastfeeding complications or potential complications
- ❒ B61 Dental problems
- ❒ B76 Inappropriate nutrition practice(s)
- ❒ B63 Dietary risk associated with complementary feeding practices and ≥ 4 months old *(Use only when no other nutrition risk criteria apply)*
- ❒ B88 Infant < 6 months born to WIC mother or born to a woman who would have been eligible during pregnancy
- ❒ B89 Breastfed infant of woman at nutritional risk
- ❒ B91 Homelessness
- ❒ B96 Migrancy
- ❒ B90 Environmental tobacco smoke exposure
- ❒ B92 Caretaker with limited abilities regarding feeding decisions / preparing food
- ❒ B93 Mother with prenatal drug or alcohol use or has mental retardation
- ❒ B94 Entered / changed foster care home(s) in the past 6 months
- ❒ B97 Recipient of abuse
- ❒ B01 Cancer
- ❒ B02 Celiac disease
- ❒ B03 Central nervous system disorders
- ❒ B05 Developmental, sensory or motor disabilities interfering with ability to eat
- ❒ B06 Diabetes mellitus
- ❒ B07 Drug-nutrient interactions
- ❒ B19 Food allergies
- ❒ B20 Gastro-intestinal disorders
- ❒ B21 Genetic and congenital disorders
- ❒ B24 Hypertension and prehypertension
- ❒ B25 Hypoglycemia
- ❒ B26 Inborn errors of metabolism
- ❒ B27 Infectious diseases
- ❒ B28 Lactose intolerance
- ❒ B29 Nutrient deficiency diseases
- ❒ B30 Other medical conditions
- ❒ B33 Recent major surgery, trauma, burns
- ❒ B34 Renal disease
- ❒ B35 Thyroid disorders

PLAN OF NUTRITION CARE

CLIENT ACTION STEPS – *Document at least one (1) behavior change or action that parent/caretaker identifies or agrees to.*

EDUCATION – *Check required topic if provided. List other topics if provided.*
Required Topic**:** ❒ Substance abuse education for parent/caretaker

ISSUANCE OF BREASTFEEDING SUPPLIES
*Specify item(s) issued**:***

*Specify reason(s) issued**:***

*Specify date issued**:***

REFERRALS – *Check box for any referral made. Write in any not listed under "Other".*

- ❒ Medicaid
- ❒ FNS (food stamps)
- ❒ Health care provider
- ❒ IBCLC
- ❒ Breastfeeding Peer Counselor
- ❒ RD
- ❒ CDSA
- ❒ Immunization Program
- ❒ Care Coordination for Children (CC4C program)
- ❒ Other(s) – *specify***:**

FOOD PACKAGE– *Check feeding option and type of food package assigned by CPA.*
Feeding option**:** ❒ Fully BF ❒ Partially BF ❒ Not BF
Food Package**:** ❒ Standard ❒ Modified (specify modifications) **:**

FOLLOW-UP – *Document timeframe and plan for follow-up.*

CPA Signature/Title/Date:

DATE	NOTES