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 POSTPARTUM WOMEN

**Breastfeeding ❒ Certification ❒ Mid-year assessment**
**Non-Breastfeeding ❒ Certification**

Client age_____ ❒ Client present
Health Insurance ❒ Medicaid ❒ Other ❒ None
Health care provider _____
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: ❒ person w/ limited abilities ❒ in foster care/date_____ ❒ homeless ❒ a migrant ❒ breastfeeding a Priority I, II, or IV infant

❒ No client-reported problem

### ANTHRO & BIOCHEMICAL

Weight at delivery _____ Total weight gained this pregnancy _____ Pre-pregnancy Weight_____ Pre-pregnancy BMI _____

Height _____ Weight _____ Date of measures _____ Current BMI _____

Hemoglobin _____Hematocrit_____Date of test_____ Blood lead_____Date of test_____

### CLINICAL

| Pregnancy Hx: Date (mm/yy) | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| Birth weight | | | | | | | | |
| Weeks gestation | | | | | | | | |
| Outcome / complications | | | | | | | | |

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

Uses: ❒ Rx medications ❒ OTC medications ❒ vitamins ❒ tobacco ❒ alcohol ❒ illegal drugs

❒ Contraception *(specify method)* _____

❒ No client-reported problem

### DIET & PHYSICAL ACTIVITY

Usual eating pattern: _____

Type of milk usually consumed: ❒ skim ❒ 1% ❒ 2% ❒ whole ❒ none ❒ other (*specify*):_____

| Behaviors *(✓frequency)* | Most days | Some days | Rarely |
|---|---|---|---|
| Is physically active | | | |
| Eats fruits | | | |
| Eats vegetables | | | |
| Drinks water | | | |

| | Most days | Some days | Rarely |
|---|---|---|---|
| Eats out or eats take-out food | | | |
| Drinks sweet drinks: soda, tea, sports/juice drinks | | | |
| Watches more than 2 hours of 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):***

- ❒ D/G41 Underweight (pre-pregnancy or current BMI < 18.5)
- ❒ D/G45 Overweight (pre-pregnancy BMI ≥ 25)
- ❒ D/G50 High maternal weight gain
- ❒ D/G22 Low hemoglobin/hematocrit
- ❒ D/G23 Elevated blood lead (≥10 ug/dL)
- ❒ D/G74 Maternal smoking
- ❒ D/G75 Alcohol and illegal drug use
- ❒ D/G40 Most recent conception was prior to 18th birthday
- ❒ D/G43 High parity and young age
- ❒ D/G44 Most recent conception ≤ 16 months of birth of infant ≥ 500 gms or 20 weeks gestation
- ❒ D/G70 History of preterm delivery (most recent pregnancy)
- ❒ D/G71 History of low birth weight infant (most recent pregnancy)
- ❒ D52 Spontaneous abortion, fetal or neonatal death (most recent pregnancy)
- ❒ G52 Fetal or neonatal death (most recent pregnancy of mutifetal gestation with at least one infant still living)
- ❒ D/G72 History of birth of a large for gestational age infant
- ❒ D/G73 Birth of infant with nutrition-related congenital or birth defect (most recent pregnancy)
- ❒ D/G55 Multifetal gestation (most recent pregnancy
- ❒ D/G68 History of gestational diabetes
- ❒ D/G69 History of preeclampsia
- ❒ G86 Breastfeeding w/ current/potential complications
- ❒ D/G61 Dental problems
- ❒ D/G79 Inappropriate nutrition practice(s)
- ❒ D/G64 Failure to meet Dietary Guidelines (*Use only when no other risk criteria apply.)*
- ❒ G83 Breastfeeding woman of infant at nutritional risk based on Priority I. II or IV risk criteria
- ❒ D/G91 Homelessness
- ❒ D/G96 Migrancy
- ❒ D/G90 Environmental tobacco smoke exposure
- ❒ D/G92 Limited ability for feeding decisions / preparing food
- ❒ D/G94 Entered / changed foster care home(s) in the past 6 months
- ❒ D/G97 Recipient of abuse
- ❒ D/G01 Cancer
- ❒ D/G02 Celiac disease
- ❒ D/G03 Central nervous system disorders
- ❒ D/G04 Depression
- ❒ D/G05 Developmental, sensory or motor disabilities interfering with ability to eat
- ❒ D/G06 Diabetes mellitus
- ❒ D/G07 Drug-nutrient interactions
- ❒ D/G08 Eating disorders
- ❒ D/G19 Food allergies
- ❒ D/G20 Gastro-intestinal disorders
- ❒ D/G21 Genetic and congenital disorders
- ❒ D/G24 Hypertension and prehypertension
- ❒ D/G25 Hypoglycemia
- ❒ D/G26 Inborn errors of metabolism
- ❒ D/G27 Infectious diseases
- ❒ D/G28 Lactose intolerance
- ❒ D/G29 Nutrient deficiency diseases
- ❒ D/G30 Other medical conditions
- ❒ D/G32 Pre-diabetes
- ❒ D/G33 Recent major surgery, trauma, burns
- ❒ D/G34 Renal disease
- ❒ D/G35 Thyroid disorders

## PLAN OF NUTRITION CARE

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

**EDUCATION –** *Check required topics if provided. List other topics if provided.*

Required Topics: ❒ Folic acid ❒ Children's immunizations

**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 | ❒ IBCLC | ❒ Dentist |
| ❒ FNS (food stamps) | ❒ Breastfeeding Peer Counselor | ❒ RD |
| ❒ Health care provider | | ❒ 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 |
|---|---|
| | |
| | |
| | |
| | |
| | |