

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
 D99 At Risk for Regression in Nutrition Status

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

D99 Certifier Signature/Title/Date:

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 inadequate water source inadequate appliances to store/cook food
 FNS (food stamps) food security issues

Client is: person w/ limited abilities homeless breastfeeding a Priority I, II, or IV infant
 in foster care/date _____ a migrant
 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		Most days	Some days	Rarely
Is physically active				Eats out or eats take-out food			
Eats fruits				Drinks sweet drinks: soda, tea, sports/juice drinks			
Eats vegetables				Watches more than 2 hours of TV			
Drinks water				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):

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

- | | | |
|---|---|--|
| <input type="checkbox"/> Medicaid | <input type="checkbox"/> IBCLC | <input type="checkbox"/> Dentist |
| <input type="checkbox"/> FNS (food stamps) | <input type="checkbox"/> Breastfeeding | <input type="checkbox"/> RD |
| <input type="checkbox"/> Health care provider | <input type="checkbox"/> Peer Counselor | <input type="checkbox"/> 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