

**WIC NUTRITION ASSESSMENT & CARE PLAN
PREGNANT WOMEN**

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 _____

Certification
 A95 Temporary Eligibility for Pregnant Women
 Client age _____ Client present
 Health Insurance Medicaid Other None
 Health care provider _____
 Date 1st prenatal visit _____ EDC _____
 Primary Language (if other than English) _____
 Name of Interpreter (if used) _____
 Household composition: # Adults _____ # Children _____

A95 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 in foster care /date _____ homeless a migrant
 No client-reported problem

ANTHRO & BIOCHEMICAL

Pre-pregnancy weight _____ Pre-pregnancy BMI _____
 Height _____ Weight _____ Date of measures _____
 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) nausea vomiting heartburn constipation
 Uses: Rx medications OTC medications prenatal vitamins tobacco alcohol illegal drugs
 Plans for infant feeding: plans to breastfeed no plans to breastfeed is undecided
 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):

- A41 Underweight prior to pregnancy (BMI <18.5)
- A45 Overweight prior to pregnancy (BMI ≥ 25)
- A48 Low maternal weight gain
- A49 Maternal weight loss during pregnancy
- A50 High maternal weight gain
- A22 Low hemoglobin/hematocrit
- A23 Elevated blood lead (≥10 ug/dL)
- A74 Maternal smoking
- A75 Alcohol and illegal drug use
- A40 Current conception prior to 18th birthday
- A43 High parity and young age
- A44 Current conception ≤ 16 months of delivery of infant ≥ 500 gms or ≥ 20 weeks gestation
- A70 History of preterm delivery
- A71 History of low birth weight
- A52 History of ≥ 2 spontaneous abortions or history of fetal or neonatal death
- A72 History of birth of a large for gestational age infant
- A73 History of birth with nutrition-related congenital or birth defect
- A54 Pregnant woman currently breastfeeding
- A55 Multifetal gestation
- A56 Fetal growth restriction (FGR)
- A66 Hyperemesis gravidarum
- A67 Gestational diabetes
- A68 History of gestational diabetes
- A69 History of preeclampsia
- A59 Inadequate prenatal health care
- A61 Dental problems
- A79 Inappropriate nutrition practice(s)
- A64 Failure to meet Dietary Guidelines (Use only when no other nutrition risk criteria apply.)
- A91 Homelessness
- A96 Migrancy
- A90 Environmental tobacco smoke exposure
- A92 Limited ability for feeding decisions / preparing food
- A94 Entered / changed foster care home(s) in the past 6 months
- A97 Recipient of abuse
- A01 Cancer
- A02 Celiac disease
- A03 Central nervous system disorders
- A04 Depression
- A05 Developmental, sensory or motor disabilities interfering with ability to eat
- A06 Diabetes mellitus
- A07 Drug-nutrient interactions
- A08 Eating disorders
- A19 Food allergies
- A20 Gastrointestinal disorders
- A21 Genetic and congenital disorders
- A24 Hypertension and prehypertension
- A25 Hypoglycemia
- A26 Inborn errors of metabolism
- A27 Infectious diseases
- A28 Lactose intolerance
- A29 Nutrient deficiency diseases
- A30 Other medical conditions
- A33 Recent major surgery, trauma, burns
- A34 Renal disease
- A35 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: Prenatal diet Breastfeeding Substance abuse

REFERRALS – Check box of any referral made. Write in any not listed under “Other”.

- Medicaid
- Dentist
- PCM (Pregnancy Care Mgmt)
- FNS (food stamps)
- RD
- Breastfeeding Peer Counselor
- Health care provider
- Other(s) -specify

FOOD PACKAGE – Check type of food package assigned by CPA.

Standard Modified (specify modifications) :

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

CPA Signature/Title/Date:

DATE	NOTES