1. Last Name                      First Name                               MI
2. Patient Number__________________
3. Date of Birth ____________________
   Month   Day   Year
                                      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

**WIC NUTRITION ASSESSMENT & CARE PLAN**

**INFANTS**

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

<table>
<thead>
<tr>
<th>MARK BOXES</th>
<th>DOCUMENT RELEVANT DETAILS</th>
</tr>
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**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
- ■ with primary caretaker with limited abilities
- ■ homeless
- ■ a migrant

Client is:
- ■ breastfed infant with Priority I or IV
- ■ mother or at-risk non-WIC mother
- ■ mother w/ prenatal drug/alcohol use or mental retardation

**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 _____________

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

**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**

- ■ Has age-appropriate physical activity
- ■ Consumes age-appropriate beverages
- ■ Consumes age-appropriate foods
- ■ Uses age-appropriate feeding skills
- ■ Consumes Vitamin D source

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

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 ☐ Breastfeeding ☐ Immunization Program
☐ FNS (food stamps) ☐ Peer Counselor ☐ Care Coordination for Children (CC4C program)
☐ Health care provider ☐ RD ☐ CDSA ☐ 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

Date of Birth:

Name: