



# Contra Costa County WIC Referral Form

**FAX** completed form with confidential cover sheet to WIC at **925-655-1730 (FAX)**

1. WIC is closed on weekends, holidays, and the first Thursday of each month.
2. Contra Costa WIC offers a limited number of hospital grade breast pumps and loans may be determined based on eligibility, as well as priority of medical need. For questions, please call **925-655-1701**.

|                      |   |  |                                 |   |                                 |  |  |
|----------------------|---|--|---------------------------------|---|---------------------------------|--|--|
| <i>Referral for:</i> | <input type="checkbox"/> Needs WIC Enrollment | <input type="checkbox"/> Lactation Support | <input type="checkbox"/> Urgent | <input type="checkbox"/> WIC Pump Request | <input type="checkbox"/> Foster | <input type="checkbox"/> Locker EBP issued # _____ | <input type="checkbox"/> CCHP Pump Ordered |
|----------------------|---|--|---------------------------------|---|---------------------------------|--|--|

|                                     |                                  |                                    |                                    |                                    |                                     |
|-------------------------------------|----------------------------------|------------------------------------|------------------------------------|------------------------------------|-------------------------------------|
| <i>Local WIC Office Preference:</i> | <input type="checkbox"/> Concord | <input type="checkbox"/> San Pablo | <input type="checkbox"/> Pittsburg | <input type="checkbox"/> Brentwood | <input type="checkbox"/> Crossroads |
|-------------------------------------|----------------------------------|------------------------------------|------------------------------------|------------------------------------|-------------------------------------|

|                               |                                  |
|-------------------------------|----------------------------------|
| Requesting Hospital / Clinic: | Today's Date:                    |
| Requesting Staff Name:        | Staff Phone #: (       )       - |

Mother's First and Last Name: \_\_\_\_\_

|                   |       |               |
|-------------------|-------|---------------|
| Mother's Address: | City: | Mother's DOB: |
|-------------------|-------|---------------|

|                                     |                     |
|-------------------------------------|---------------------|
| Mother's Phone #: (       )       - | Preferred Language: |
|-------------------------------------|---------------------|

|                                      |  |
|--------------------------------------|--|
| Alternate Phone #: (       )       - | <i>Does the family have any other children under 5 years old?</i><br>Yes or No<br><i>Are they enrolled on WIC?</i> Yes or No |
|--------------------------------------|--|

|                 |  |  |  |
|-----------------|--|--|--|
| Feeding Method: | <input type="checkbox"/> Exclusively Breastfeeding | <input type="checkbox"/> Combination Feeding | <input type="checkbox"/> Formula Feeding |
|-----------------|--|--|--|

Baby's First and Last Name: \_\_\_\_\_

|             |                    |                               |
|-------------|--------------------|-------------------------------|
| Baby's DOB: | Baby's sex: M or F | Birth at: _____ Wks. Gest Age |
|-------------|--------------------|-------------------------------|

|                     |               |  |
|---------------------|---------------|--|
| Baby's Birthweight: | Birth length: | Delivery Type:                      Gravida____ Para____ |
|---------------------|---------------|--|

Diagnosis: \_\_\_\_\_

Reason for Referral or Pump Request: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

By initialing this WIC referral form, I authorize the referring hospital to share the above contact information with Contra Costa Health Services, WIC Program. \_\_\_\_\_

Al firmar esta forma de referencia de WIC yo autorizo al hospital que comparta la información de contacto que está en la parte superior de esta forma al programa de WIC en Contra Costa. \_\_\_\_\_ Verbal Consent Received: \_\_\_\_\_

**For Office Use Only: WIC ID#** \_\_\_\_\_