HOSPITAL FORM FOR WIC

Please complete and fax along with prescription

Mother's Name _____ Medical Card # _____

Infant's Name _____ Medical Card # _____

Reason for pump use (check all that apply):

- ❒ Prematurity
- ❒ Medical condition affecting ability to suck
- ❒ Mother-infant separation/interruption of breastfeeding for >24 hours due to medical condition
- ❒ Weight loss >7% in first 72 hours of life
- ❒ Mastitis
- ❒ Severe engorgement or soreness
- ❒ Other (needs approval) _____

Name of requesting physician _____

Infant information:

Date of birth _____

Birth weight _____ Birth length _____

Currently hospitalized? ❒ Yes ❒ No

Times/day pumping _____ Times/day nursing _____

Using formula? ❒ Yes ❒ No Ounces/day _____

The WIC Program is an equal opporunity provider and employer.