DHS
Oregon Department
of Human Services

Cert Data Entry Document
Women, Infants & Children

Client Primary

WIC ID Number: ______________________ Participant Name: ____
Last First

Date of Birth: _____/______/_______ Gender: _____________

Address—Type: _____________ Address: ____
Street City Zip

Phone—Type: _______________ Phone Number: (_________)__________________

Guardian's Name: ____ Type: ___________________
Last First

Race: ____________ Ethnicity: ____________ Spoken Lang: ____________ Written Lang: ____________

Transaction Type:_______________

Income Eligibility

Proof of ID: _____________ Proof of Residency: _____________ No. in family: ________ Unborn: _______

❑ Food Stamps ❑ OHP ❑ TANF ❑ Eligibility Pending

Income Provider	Interval	Amount	Source	Proof of Income

WIC Intake

Other family members on WIC? ❑ Yes ❑ No Clinic: _________________ WIC Category: ______________

Migrant: ❑ Yes ❑ No Homeless: ❑ Yes ❑ No Contact by phone: ❑ Yes ❑ No

Contact by mail: ❑ Yes ❑ No Auto-scheduler: ❑ Yes ❑ No

For women only:
Voter registration offered? ❑ Yes ❑ No Marital Status: ___________ Education: ___________

Certification Start Date: _____/_____/_____ Term/Ineligibility Reason(s): ___________________________________

Medical Data—Woman, Infant & Child

ANTHROPOMETRIC: Collection Date: ______/______/______ Weight: __________ lbs. __________ oz.

Length/Height: _______ in. _______ 1/8th ❑ Recumbent ❑ Standing

BIOCHEMICAL: Collection Date: ______/______/______ hgb: _________ hct: __________

Completed by:___________________________________ **Date data collected:**________________

Complete both sides

Other Medical Data

INFANTS: ☐ Premature Weeks Gestation: ________ Birth Weight: __________ Birth Length: ___________

PRENATAL: EDD: ____/_____/______ or LMP: ________/______/______ Pre-pg Wt.: _______ Lbs _____oz

Weeks Gestation: _________________

POSTPARTUM: Actual Delivery Date: ________/______/______ EDD: ________/______/______

Total Weight Gain: _________ lbs _________ oz

✓ **Attach the *dated* "Health Questionnaire" and "Diet Questions" forms.**

NE Plan

Counseling Topic: ____

Client Goals: ____

____

Risks: ____

Referral to OHP: ☐ Yes ☐ No Risk level: _________________

Appointments

PREFERENCES: Clinic: __________ Staff: _________________ Time: **a.m. p.m. eve.** DOW: ___________

Interpreter: ______________ Language: ______________

NEXT APPOINTMENTS:

Month: _______ Type: _____ Topic: ___________ Title/Code: ____________________ Auto-Sched: ☐ Yes ☐ No

Month: _______ Type: _____ Topic: ___________ Title/Code: ____________________ Auto-Sched: ☐ Yes ☐ No

NE refused: ________________ Non-WIC NE: _______________________________

Food Package

Food Pkg Code: _________ or Food Pkg Descr.: ___________ Start Date: ___________ End Date: ________

Food Pkg Code: _________ or Food Pkg Descr.: ___________ Start Date: ___________ End Date: ________

Prescription: ☐ Received ☐ HP Approved ℞ Start Date: __________ ℞ End Date: ___________

Special Client: ☐ Yes ☐ No

FI Issuance: Number of months to print: ______ ☐ Mail to client ☐ Will pick up _______________

✓ **Attach any additional notes and specify which section.**

WIC is an equal opportunity program and employer.