Illinois State WIC Program
Category: Pregnant
R- 01.21 WIC Paper Assessment Tool

Date: _____ CPA Initials: _____

Paper Certification Form – Pregnant Woman

For initial certifications, the WIC ID number and/or HH ID number may not be available. The automated system will generate a WIC ID number and/or HH ID number, if needed, when data is entered, and it should be recorded on this form at that time.

Applicant/Participant Name: _____ **Applicant/Participant DOB:** _____
(Risk 331 Pregnancy at a Young Age)

ID #: _____ **EBT card #:** _____

CPA Name: _____ **HH ID#:** _____

Date of Visit: _____ **Date Data Entered in IWIC:** _____

Mandatory questions are **bolded** and/or preceded by a star (*). Mandatory questions must be completed through participant-centered discussions. **Use IWIC MIS Flowsheets –** for steps to complete during a CERT appointment.

Responses that generate a nutrition risk including high risks have the risk number identified in parenthesis near applicable questions and answers. Indicate all risks generated from questions on each page in the Nutrition Risk(s) Identified section on the bottom of each page, if applicable. Refer to the I-WIC Nutrition Risk Criteria to assist with risk and priority assignment.

Complete the following questions related to Cert Action.

***Is applicant/participant physically present?** ☐ Yes ☐ No

***If not, reason not present:**

☐ Medical Condition	☐ Working Parents or Caretakers
☐ Natural Disaster	☐ Other

***Transfer?** ☐ Yes ☐ No

Last Menstrual Period (LMP): ___/___/___ ***Expected Delivery Date (EDD):** ___/___/___
(Risk 331: Pregnancy at a Young Age)

Complete the following sections related to Breastfeeding.

BF Questions:

1. *How are you thinking about feeding your baby?

- ☐ I want to nurse my baby from the breast
- ☐ I want to pump and nurse from the breast
- ☐ I want to pump only
- ☐ I want to provide both formula and breast milk
- ☐ I don't want to breastfeed
- ☐ Other: _____

2. *Have you ever breastfed/pumped? ☐ Yes ☐ No

3. *Tell me about your breastfeeding experience or what you have heard about breastfeeding?

Nutrition Risk(s) Identified:

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4. *Are you experiencing any of the following? (Risk 602: BF Complications / potential Complications only applies if currently breastfeeding)

- ☐ Cracked, bleeding or severely sore nipples
- ☐ Flat or inverted nipples
- ☐ Mastitis
- ☐ No milk at 4 days postpartum
- ☐ Recurrent plugged ducts
- ☐ Severe breast engorgement
- ☐ Tandem nursing
- ☐ 40 years of age or older
- ☐ Other
- ☐ None

BF Support & Notes:

CONTACT HISTORY

*Date:	Role	*Method	Contact made	*Topic/No Contact	Call Back Date	Achieved Date
___/___/____	☐ BFC/PC SPVR	☐ Clinic Visit	☐	☐ Breastfeeding Basics		
Baby name: _____	☐ CPA	☐ Group/class	☐	☐ Breastpumps/Pumping		
	☐ DBE	☐ Home visit	☐	☐ Common BF Concerns		
	☐ PC	☐ Hospital visit	☐	☐ General Support		
		☐ Phone/Text	☐	☐ Return to Work/School		
				☐ Supplemental Feedings		
				☐ Weaning		

BREASTFEEDING REFERRAL

	*Referred To	*Reason for referral(s)	Reason Not Referred	Referral Type	Follow-up date
*Date referred: ____/____/_____	☐ WIC BF Support Group	☐ Breastfeeding Problems	☐ Baby Adopted/ Foster Care	☐ PN	
	☐ BFC/PC SPVR	☐ Education	☐ CPA Professional Judgement	☐ PP	
	☐ Community Support	☐ Medical Condition - Baby	☐ Infant Death		
	☐ DBE	☐ Medial Condition – Mother	☐ No Local Referral Resource Available		
	☐ Health Care Provider	☐ Support	☐ Participant Declined		
	☐ IBCLC				
	☐ No Referral Made				
	☐ PC				

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BREASTFEEDING NOTES

***Date:**
***Staff:**
Baby Name:
***Note:**

BF Pumps & Aids *(if applicable)*

***Date Assigned** *MM/DD/YYYY*	***BF Aid Type**	***Serial Number**	Issued By	***Reason Assigned**	***Due Date**	Date Returned

☐ Non-WIC Breast pump	☐ Medicaid	☐ Private Insurance	☐ Paid out of pocket Manufacturer:	☐ Hospital owned loaner pump

Breastfeeding Support	
☐ Female Household member	☐ Male Household member
☐ Friend	☐ Health care provider
☐ Peer counselor	☐ Other _____

Nutrition Risk(s) Identified: