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

Date: _____ CPA Initials:_____

Paper Certification Form – Breastfeeding 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.

BF Status Change/Information:

Assign NP status due to perinatal loss or adoption:
□ No □ Yes

***Are you currently breastfeeding or pumping?**	□ No	□ Yes		
Are you currently giving your baby any supplemental formula?	□ No	□ Yes		
Frequency	□ Some	□ Mostly		
***Did you ever breastfeed or feed your baby breast milk?**	□ No	□ Yes	□ Unknown	
How old was your baby when he/she was first fed something other than breast milk (i.e., formula, water, infant cereal, etc.)?	___Months	____Weeks	_____Days	□ Unknown
Age BF Ceased	____Months	____Weeks	_____Days	□ Unknown

Reason BF Ceased

□ **Doctor Advised**	□ **Met Breastfeeding Goal**
□ **Baby Refused/Prefers Bottle**	□ **Mother Taking Medication**
□ **Birth Control Interfered**	□ **Not Enough Milk/Baby Not Satisfied**
□ **Just Did Not Like Breastfeeding**	□ **Other (See BF Note)**
□ **Lack of Support (Not Workplace)**	□ **Pain or Latching Difficulty**
□ **Lack of Workplace Support**	□ **No reason provided**

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***Did you Breastfeed as long as you desired?** ☐ No ☐ Yes

Participant Category ☐ BE ☐ BP

***Actual Delivery Date:**___/___/___

*** Present for Cert?** ☐ No ☐ Yes

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

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

Complete the following sections related to Breastfeeding.

BF Questions:

*** 1. How many times is the baby breastfeeding or given breast milk in a day (24 hours)?** _____

*** 2. Are you experiencing any of the following?**

- ☐ 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

(Risk 602, if select any option except "Other" and "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		

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BREASTFEEDING REFERRAL

	*Referred To	*Reason referred	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	☐ Medical Condition – Mother	☐ No Local Referral Resource Available		
	☐ Health Care Provider	☐ Support	☐ Participant Declined		
	☐ IBCLC				

BREASTFEEDING NOTES

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

BF Pumps & Aids

*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: