# Contra Costa County
# WIC Lactation Referral Form

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

***Please note: COVID-19 UPDATE – WIC is providing remote services only***

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.

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|---|---|---|---|---|
| *Referral for:* | ☐ Needs WIC Enrollment | ☐ Lactation Support | ☐ WIC Pump Request | ☐ Locker EBP issued #_____<br>☐ CCHP Pump Ordered |
| *Local WIC Office Preference:* | ☐ Concord | ☐ San Pablo | ☐ Pittsburg | ☐ Brentwood<br>☐ 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 #: ( ) - | *Does the family have any other children under 5 years old?* Yes or No<br>*Are they enrolled on WIC?* Yes or No |

| | | |
|---|---|---|
| Feeding Method: | ☐ Exclusively Breastfeeding | ☐ Combination Feeding ☐ Formula Feeding |
| Baby's DOB: Baby's sex: M or F | | Birth at: ☐ Full-Term<br>☐ Pre-Term Birth: _____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#**