1. Last Name First Name M I

2. Patient Number — H

3. Date of Birth Month Day Year

4. Race ☐ 1. White ☐ 2. Black/African American
☐ 3. American Indian/Alaska Native ☐ 4. Asian
☐ 5. Native Hawaiian/Other Pacific Islander ☐ 6. Unknown

Ethnicity: Hispanic/Latino Origin? ☐ Yes ☐ No

5. Sex ☐ 1. Male ☐ 2. Female

6. County of Residence

North Carolina Department of Health and Human Services
Division of Public Health
Women's and Children's Health Section
Nutrition Services Branch • WIC Program

WIC PROGRAM EXCHANGE OF INFORMATION – WOMEN –

WIC is an Equal Opportunity Program.

RETURN COMPLETED FORM TO:

Local WIC Agency / Address / Phone

I authorize the exchange of the information below between the WIC Program and my Health Care Provider.

Client's Signature: _____

Date: _____

↓ ***Information Below To Be Completed By The Health Care Provider*** ↓

1. Actual or expected date of delivery: _____

2. Prepregnancy weight (if available): _____

3. Enter date and results of ***most recent*** measurements:
   Date _____ Weight _____
   Date _____ Height _____
   Date _____ Hemoglobin _____ OR Hematocrit _____

4. Obstetric history:

5. Special instructions for nutritional support:

6. Would you like to receive a summary of nutrition services provided by the WIC Program staff? ❑ Yes ❑ No

Completed by: _____ **Date:** _____ **Phone:** _____
Signature/Title

SUMMARY OF NUTRITION SERVICES ***(to be completed by the WIC Program Staff)***

Completed by: _____ **Date:** _____ **Phone:** _____
Signature/Title

The North Carolina WIC Program operates in all 100 counties in North Carolina.
For more information, go to www.nutritionnc.com or contact your local WIC Program.

DHHS 3492 (Revised 1/2006)
DPH/WCHS/Nutrition Services Branch/WIC Program (Review 1/2007)

WIC Program Exchange of Information
(DHHS 3492)

PURPOSE: To facilitate the exchange of information necessary for WIC certification between a health care provider and the local WIC Program.

GENERAL INSTRUCTIONS: WIC Program staff should complete the appropriate side of the form (infants/children or women) with the following information and forward it to the individual's health care provider (e.g., faxed, mailed, or given to the individual to take to the health care provider).

- **WIC Agency Name, Address, & Phone Number** of local WIC Program where person receives program services.
- **Patient Name & DOB (date of birth)** of individual being certified for WIC.
- **Client's Signature with Date** authorizing the exchange of information.

The health care provider should complete the relevant medical information, sign and date the form, and return it to the Local WIC Program.

If requested, the local WIC Program should provide a summary of nutrition services to the referring individual.

DISTRIBUTION: Maintain a copy of the WIC Program Exchange of Information form in the Health Record. Send a copy to the referring health care provider if requested.

DISPOSITION: This form may be destroyed in accordance with the Patient Clinical Records Standard of the *Records Disposition Schedule* published by the Division of Archives and History.

REORDER INFORMATION: Additional copies of this form may be ordered on the Nutrition Services Branch Requisition Form, DHHS 2507, from:

Nutrition Services Branch
1914 Mail Services Section
Raleigh, NC 27699-1914