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

Date: _____ CPA Initials: _____

Paper Certification Form – Infant

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

Applicant/Participant Name: _____**Gender: M / F**	**Applicant/Participant DOB:** _____
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-WC 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

***Is the baby currently breastfeeding or being given pumped breast milk?**	□ Yes	□ No		
Is the baby currently receiving any supplemental formula?	□ Yes	□ No		
Frequency of breastfeeding? Refer to breastfeeding NPS	□ Some	□ Mostly		
***Was the baby ever breastfed or fed breast milk?**	□ Yes	□ No	□ Unknown	
How old was the baby when he/she was first fed something other than breast milk (i.e., formula, water, infant cereal, etc.)?	___Months	____Weeks	_____Days	□ Unknown
Age Breastfeeding Ended	____Months	____Weeks	_____Days	□ Unknown

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Reason Breastfeeding Ended	☐ **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**

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

Participant Category ☐ IBE ☐ IBP ☐ IFF

*** Present for Cert?** ☐ Yes ☐ No

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

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

Complete the following sections related to Breastfeeding.

BF Questions

1. If your baby is less than one month old, do you have any existing mother/infant conditions that may impact your milk supply or ability to breastfeed?

☐ Separation of mother and infant for medical reasons	☐ Mother with previous breast surgery/trauma	☐ Cleft plate/lip or other congenital abnormalities
☐ Multiple birth	☐ Delayed lactation	☐ Medications affecting breastmilk supply
☐ Insufficient glandular tissue	☐ Hormonal/endocrine abnormalities (PCOS, DM, Thyroid Issues)	☐ QN/CPA professional judgement

2. *Does your breastfeeding baby have?

☐ Difficulty with Latch-on	☐ Weak Suck
☐ Jaundice	☐ Inadequate Stooling
☐ Other	☐ None:

(Risk 603, if select any option except "Other" and "None")

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

(Risk 411.07, if any number between 0 to 7 is entered for exclusively breastfed baby)

Nutrition Risk(s) Identified:

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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

*Date referred:	*Referred To	*Reason referred	Reason Not Referred	Referral Type	Follow Up Date
____/____/_____	☐ 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:

Nutrition Risk(s) Identified: