West Virginia Department of Health and Human Resources
RIGHT FROM THE START PROGRAM
RFTS/WIC PARTICIPANT REQUEST FOR INFORMATION

(TO BE COMPLETED BY THE RIGHT FROM THE START DESIGNATED CARE COORDINATOR)

PRENATALS	**Participant Name:** _____ (Last Name, First Name, (MI)) **Participant Address:** _____
INFANTS	**Parent's Name:** _____ (Last Name, First Name, (MI)) **Parent's Address:** _____

SPECIFIC INFORMATION REQUESTED

❑ Diet History	❑ Hemoglobin/Hematocrit	❑ Pre-Pregnancy Weight
❑ 24 Hour Recall	❑ Head Circumference	❑ Verification of Appointments
❑ Height/Length	❑ Birth Weight	❑ Current Status as WIC Participant
❑ Weight	❑ Weight Gain During Pregnancy	❑ Breastfeeding Status

_____ _____
Signature - RFTS Designated Care Coordinator Date

PLEASE SEND REQUESTED INFORMATION TO	_____ _____ _____ _____

(For completion by WIC Staff)

❑ Check if verbal request

_____
Date request received

_____ _____
Signature of WIC Staff Date responded to request