Georgia Department of Public Health

Brenda Fitzgerald, MD, Commissioner | Nathan Deal, Governor

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MEMORANDUM

ACTION MEMO #17-16

TO: District Nutrition Services Directors

FROM: Angela Hammond-Damon, IBCLC
Deputy Director, Operations and Nutrition Services
Georgia WIC Program

DATE: July 17, 2017

SUBJECT: FFY 2018 Nutrition Risk Criteria Handbook

This memorandum is being written to provide guidance on the implementation of the FFY 2018 Nutrition Risk Criteria Handbook. The revised nutrition risk criteria are effective **August 7, 2017**.

The State WIC Office is conducting a live web-based training, discussing all revisions, on July 26, 2017, from 1:00 pm to 1:45 pm. The training will also be recorded and made available on SABA. Each district is strongly encouraged to have staff attend the live web-based training, as there will be opportunity for questions and answers. Districts must ensure that CPAs attend the web-based training or view the recorded training.

All paper copies of the Nutrition Risk Criteria Handbook should be updated by replacing the revised pages. Replacement pages have been provided (Attachment A). When printing, make sure the appropriate pages are double-sided. Printing the pages to match the already assigned color coding for each category is suggested. The entire FFY 2018 Nutrition Risk Criteria Handbook will be available on the District Resources page on August 7, 2017.

Below is the list of revised criteria and changes (See Attachment A for details):

1. 135 - Slowed/Faltering Growth Pattern: New name and definition. No longer used for children.
2. 321 - History of Spontaneous Abortion, Fetal or Neonatal Loss: New name and definition was changed to include spontaneous abortion.
3. 332 - Short Interpregnancy Interval: The definition was changed. This criteria is now specific to previous pregnancies ending in live births.
4. 352 - Infectious Diseases: The criteria has been divided, for all WIC types, into two parts: Acute and Chronic. The information was separated to better address the distinctions between these acute and chronic conditions.
5. Appendix A-1 "Women's Health Recommended Guidelines For Iron Supplementation Based On Treatment Values": Updated hemoglobin (hgb) values for consistent wording.
6. Appendix A-2 "Child Health Recommended Guidelines For Iron Supplementation Based On Treatment Values": Updated hemoglobin (hgb) values for consistent wording.

7. Appendix B-3 "Definition of Inadequate Growth for Infants 1-6 Months of Age": Page was removed.

Action Steps:

1) Ensure staff attend the web-based training on July 26, 2017.
2) Make arrangements for staff not able to attend the live web-based training to view the recorded training on SABA.
3) Ensure all CPA staff receive the revised pages of the Nutrition Risk Criteria Handbook.
4) Update 2017 Risk Handbooks with the replacement pages and remove Appendix B-3 page from the 2017 Risk Handbook.

In regards to additional questions or concerns, please contact Angela Bradford at 404-463-1716 or via email at angela.bradford@dph.ga.gov.

Attachments

c: LaToya Osmani, MPH - Deputy Director, Division of Health Promotion
Acting Director, Georgia WIC Program
District Health Directors
District Program Managers
WIC Deputy Managers
WIC Managers

GEORGIA DEPARTMENT OF PUBLIC HEALTH/GEORGIA WIC

Nutrition Risk Criteria Handbook

FFY 2018

Effective Aug 2017

Georgia WIC Program
Office of Operations and Nutrition Services

Georgia Department of Public Health

2018 Risk Handbook Summary of Updates

Cover Page: Date Change

Prenatal Women: Pink

Page 7 – History of Spontaneous Abortion, Fetal or Neonatal Loss (Risk Name and Definition Change)

Page 7 – Short Interpregnancy Interval (Definition Change)

Page 14 – Infectious Diseases (Definition Change)

Breastfeeding Women: Green

Page 24 – History of Spontaneous Abortion, Fetal or Neonatal Loss (Risk Name and Definition Change)

Page 25 – Short Interpregnancy Interval (Definition Change)

Page 31 – Infectious Diseases (Definition Change)

Page 38 – Breastfeeding Mother of Infant at Nutritional Risk (Risk Name Change)

Postpartum Non-Breastfeeding Women: Yellow

Page 44 – History of Spontaneous Abortion, Fetal or Neonatal Loss (Risk Name and Definition Change)

Page 45 – Short Interpregnancy Interval (Definition Change)

Page 51 – Infectious Diseases (Definition Change)

Infants: Blue

Page 62 – Slowed/Faltering Growth Pattern (Risk Name and Definition Change)

Page 69 – Infectious Diseases (Definition Change)

Children: Orange

Page 83 – Inadequate Growth (Risk Removed)

Page 89 – Infectious Diseases (Definition Change)

Appendices: White

Page 101 – Appendix A-1: Women's Health Recommended Guidelines For Iron Supplementation Based On Treatment Values (Updated hgb values for consistent wording)

Page 102 –Appendix A-2: Child Health Recommended Guidelines For Iron Supplementation Based On Treatment Values (Updated hgb values for consistent wording)

Page 106 – Appendix B-3: Definition of Inadequate Growth for Infants 1-6 Months of Age (Removed)

PREGNANT WOMEN		
CODE		PRIORITY
132	GESTATIONAL WEIGHT LOSS DURING PREGNANCY • During first (0-13 weeks) trimester, any weight loss below pregravid weight; based on pregravid weight and current weight. OR • During second and third trimesters (14-40 weeks gestation), ≥2 lbs. weight loss. Based on two weight measures recorded at 14 weeks gestation or later. Document: Two weight measures as specified above High Risk: Weight loss of ≥2 lbs. in the second and third trimesters	I
133	HIGH MATERNAL WEIGHT GAIN High maternal weight gain at any point in pregnancy, such that a pregnant women's weight plots at any point above the top line of the appropriate weight gain range for her respective prepregnancy weight category.	I
211	ELEVATED BLOOD LEAD LEVELS Blood lead level of ≥ 5 μg/deciliter within the past 12 months. Document: Date of blood test and blood lead level in the participant's health record. Must be within the past 12 months. High Risk: Blood lead level of ≥ 5 μg/deciliter within the past 12 months.	I
301	HYPEREMESIS GRAVIDARUM Severe nausea and vomiting to the extent that the pregnant woman becomes dehydrated and acidotic. Presence of hyperemesis gravidarum diagnosed by a physician as self-reported by applicant/participant/caregiver; or as reported or documented by a physician, or a health professional acting under standing orders of a physician. Document: Diagnosis and the name of the physician that is treating this condition in the participant's health record High Risk: Diagnosed hyperemesis gravidarum	I

PREGNANT WOMEN		
CODE		PRIORITY
302	GESTATIONAL DIABETES Gestational diabetes mellitus (GDM) is defined as any degree of glucose/carbohydrate intolerance with onset or first recognition during pregnancy. Presence of condition diagnosed, documented, or reported by a physician or someone working under a physician's orders, or as self-reported by applicant/participant/caregiver. Document: Diagnosis and name of the physician that is treating this condition in the participant's health record. High Risk: Diagnosed gestational diabetes	I
303	HISTORY OF GESTATIONAL DIABETES History of diagnosed gestational diabetes mellitus (GDM) Presence of condition diagnosed by a physician as self-reported by applicant/participant/caregiver; or as reported or documented by physician, or someone working under physician's orders. Document: Diagnosis and name of the physician that is treating this condition in the participant's health record.	I
304	HISTORY OF PREECLAMPSIA History of diagnosed preeclampsia Presence of condition diagnosed by a physician as self-reported by applicant/participant/caregiver; or as reported or documented by physician, or someone working under physician's orders Document: Diagnosis and name of the physician that treated this condition in the participant's health record.	I
311	HISTORY OF PRETERM DELIVERY Any history of infant(s) born at 37 weeks gestation or less Document: Delivery date(s) and weeks gestation in participant's health record	I

PREGNANT WOMEN		
CODE		PRIORITY
312	HISTORY OF LOW BIRTH WEIGHT INFANT(S) Woman has delivered one (1) or more infants with a birth weight of less than or equal to 5 lb. 8 oz. (2500 g). Document: Weight(s) and birth date(s) in the participant's health record	I
321	HISTORY OF SPONTANEOUS ABORTION, FETAL OR NEONATAL LOSS Any 2 or more spontaneous abortions (death occurring at < 20 weeks gestation), fetal death(s) (death greater than or equal to 20 weeks gestation) or neonatal death(s) (death occurring from 0-28 days of life). This does not include elective abortions. Document: Date(s) of spontaneous abortions, fetal/neonatal death(s) in the participant's health record; weeks gestation for spontaneous abortions, weeks gestation for fetal death(s); age, at death, of neonate(s).	I
331	PREGNANCY AT A YOUNG AGE For current pregnancy, Conception at less than or equal to 17 years of age. Document: Age at conception on the WIC Assessment/Certification Form High Risk: Conception at less than or equal to 17 years of age.	I
332	SHORT INTERPREGNANCY INTERVAL For current pregnancy, the participant's EDC is less than 25 months after the live birth of the last pregnancy. Document: Delivery date of last birth and EDC in the participant's health record	I

PREGNANT WOMEN		
CODE		PRIORITY
333	HIGH PARITY AND YOUNG AGE The following two (2) conditions must both apply: 1. The woman is under age 20 at date of conception, AND 2. She has had 3 or more previous pregnancies of at least 20 weeks duration, regardless of birth outcome. Document: EDC date; number of pertinent pregnancies (of at least 20 weeks gestation) and weeks gestation for each, in the participant's health record	I
334	LACK OF, OR INADEQUATE PRENATAL CARE Prenatal care beginning after the 1st trimester (0-13 weeks) Document: Weeks gestation, in participant's health record, when prenatal care began. A pregnancy test is not prenatal care.	I
335	MULTI-FETAL GESTATION More than one (>1) fetus in a current pregnancy. Document: Diagnosis and name of the physician that is treating this condition in the participant's health record. High Risk: Multi-fetal gestation	I
336	FETAL GROWTH RESTRICTION Fetal Growth Restriction (FGR) (replaces the term Intrauterine Growth Retardation (IUGR), may be diagnosed by a physician with serial measurements of fundal height, abdominal girth and can be confirmed with ultrasonography. FGR is usually defined as a fetal weight <10th percentile for gestational age. Presence of condition diagnosed, documented, or reported by a physician or someone working under a physician's orders, or as self-reported by applicant/participant/caregiver. Fetal Growth Restriction (FGR) must be diagnosed by a physician or a health professional acting under standing orders of a physician. Document: Diagnosis in participant's health record High Risk: Fetal Growth Restriction	I

PREGNANT WOMEN		
CODE		PRIORITY
349	GENETIC AND CONGENITAL DISORDERS Hereditary or congenital condition at birth that causes physical or metabolic abnormality, or both. May include, but not limited to: cleft lip, cleft palate, thalassemia, sickle cell anemia, down's syndrome. Presence of genetic and congenital disorders diagnosed by a physician as self-reported by applicant/participant/caregiver; or as reported or documented by a physician, or a health professional acting under standing orders of a physician. Document: Diagnosis and the name of the physician that is treating this condition in the participant's health record. High Risk: Diagnosed genetic/congenital disorder	I
351	INBORN ERRORS OF METABOLISM Gene mutations or gene deletions that alter metabolism in the body, including, but not limited to: phenylketonuria (PKU), maple syrup urine disease, galactosemia, hyperlipoproteinuria, homocystinuria, tyrosinemia, histidinemia, urea cycle disorder, glutaric aciduria, methylmalonic acidemia, glycogen storage disease, galactokinase deficiency, fructoaldase deficiency, propionic acidemia, hypermethioninemia. Presence of inborn errors of metabolism diagnosed by a physician as self-reported by applicant/participant/caregiver; or as reported or documented by a physician, or a health professional acting under standing orders of a physician. Document: Diagnosis and the name of the physician that is treating this condition in the participant's health record. High Risk: Diagnosed inborn error of metabolism	I

PREGNANT WOMEN		
CODE		PRIORITY
352	INFECTIOUS DISEASES **Acute Infectious Diseases:** A disease which is characterized by a single or repeated episode of relatively rapid onset and short duration. Acute infectious diseases include, but are not limited to: Hepatitis A, Hepatitis E, Meningitis (Bacterial/Viral), Parasitic Infections, Listeriosis, Pneumonia, Bronchitis (3 episodes) The acute infectious disease must be present within the past 6 months. Document: Diagnosis, appropriate dates of each occurrence, and name of physician treating condition in the participant's health record.	I
	Chronic Infectious Diseases: Conditions likely lasting a lifetime and require long-term management of symptoms. Chronic infectious diseases include, but are not limited to: HIV/AIDS, Hepatitis D, Hepatitis B, and Hepatitis C. Document: Diagnosis and name of physician treating condition in the participant's health record. When using HIV/AIDS positive status as a Nutritionally Related Medical Condition, write "See Medical Record" for documentation purpose. High Risk: Diagnosed infectious disease, as described above	
353	FOOD ALLERGIES An adverse immune response to a food or a hypersensitivity that causes adverse immunologic reaction. Presence of condition diagnosed, documented, or reported by a physician or someone working under a physician's orders, or as self-reported by applicant/participant/caregiver. Document: Diagnosis and the name of the physician that is treating this condition in the participant's health record. High Risk: Diagnosed food allergy.	I

PREGNANT WOMEN	
CODE	PRIORITY
381 ORAL HEALTH Diagnosis of oral health conditions diagnosed, documented, or reported by a physician, dentist, or someone working under a physician's orders, or as self-reported by applicant/participant/caregiver. • Dental Caries • Periodontal Disease – Gingivitis or periodontitis • Tooth Loss - ineffectively replaced teeth or oral infections which impair the ability to ingest food in adequate quantity or quality. Document: Oral Health Condition and name of physician, dentist or someone working under a doctor's orders that is treating this condition in the participant's health record.	I
400 INAPPROPRIATE NUTRITION PRACTICES Routine nutrition practices that may result in impaired nutrient status, disease, or health problems. (Appendix E) Document: Inappropriate Nutrition Practice(s) in the participant's health record.	IV
401 FAILURE TO MEET DIETARY GUIDELINES A woman who meets eligibility requirements based on category, income, and residency but who does not have any other identified nutritional risk factor may be presumed to be at nutritional risk based on failure to meet the Dietary Guidelines for Americans. (This risk factor may be assigned only when a woman does not qualify for risk 400 or for any other risk factor.)	IV
502 TRANSFER OF CERTIFICATION Person with a current valid Verification of Certification (VOC) document from another state or local agency. The VOC is valid until the certification period expires, and shall be accepted as proof of eligibility for Program benefits. If the receiving local agency has waiting lists for participation, the transferring participant shall be placed on the list ahead of all other waiting applicants. This criterion should be used primarily when the VOC card/document does not reflect another more specific nutrition risk condition at the time of transfer or if the participant was initially certified based on a nutrition risk condition not in use by the receiving agency.	I, IV

PREGNANT WOMEN		
CODE		PRIORITY
602	BREASTFEEDING COMPLICATIONS OR POTENTIAL COMPLICATIONS A breastfeeding woman with any of the following complications or potential complications for breastfeeding. a. severe breast engorgement b. recurrent plugged ducts c. mastitis d. flat or inverted nipples e. cracked, bleeding or severely sore nipples f. age ≥ 40 years Document: Complications or potential complications in the participant's health record. High Risk: Refer to or provide the mother with appropriate breastfeeding counseling.	I
801	HOMELESSNESS Homelessness as defined in the Special Populations Section of the Georgia WIC Program Procedure Manual.	IV
802	MIGRANCY Migrancy as defined in the Special Populations Section of the Georgia WIC Program Procedures Manual.	IV
901	RECIPIENT OF ABUSE Battering (abuse) within past 6 months as self-reported, or as documented by a social worker, health care provider or on other appropriate documents, or as reported through consultation with a social worker, health care provider or other appropriate personnel. Battering refers to violent assaults on women.	IV
902	PRENATAL WOMAN WITH LIMITED ABILITY TO MAKE FEEDING DECISIONS AND/OR PREPARE FOOD Woman who is assessed to have limited ability to make appropriate feeding decisions and/or prepare food. Examples may include: • mental disability / delay and/or mental illness such as clinical depression (diagnosed by a physician or licensed psychologist) • physical disability which restricts or limits food preparation abilities • current use of or history of abusing alcohol or other drugs Document: The women's specific limited abilities in the participant's health record.	IV
903	Foster Care Entering the foster care system during the previous six months or moving from one foster care home to another foster care home during the previous six months.	IV
904	ENVIRONMENTAL TOBACCO SMOKE EXPOSURE Environmental tobacco smoke (ETS) exposure is defined as exposure to smoke from tobacco products inside the home.	I

BREASTFEEDING WOMEN		
CODE		PRIORITY
133	HIGH MATERNAL WEIGHT GAIN Breastfeeding (most recent pregnancy only): total gestational weight gain exceeding the upper limit of the recommended range based on Body Mass Index (BMI), as follows: Prepregnancy Weight Group / Definition (BMI) / Cut-off Value (Singleton) / Cut-off Value (Multi-Fetal) Underweight: < 18.5; >40 lbs.; * Normal Weight: 18.5 to 24.9; >35 lbs.; >54 lbs. Overweight: 25.0 to 29.9; >25 lbs.; >50 lbs. Obese: ≥ 30.0; >20 lbs.; >42 lbs. *There are no provisional guidelines for underweight woman with multiple fetuses. (Appendix B-2) Document: Pre-gravid weight and last weight before delivery	I
211	ELEVATED BLOOD LEAD LEVELS Blood lead level of ≥ 5 μg/deciliter within the past 12 months. Document: Date of blood test and blood lead level in the participant's health record. Must be within the past 12 months. High Risk: Blood lead level of ≥ 5 μg/deciliter within the past 12 months.	I
303	HISTORY OF GESTATIONAL DIABETES History of diagnosed gestational diabetes mellitus (GDM) Presence of condition diagnosed by a physician as self-reported by applicant/participant/caregiver; or as reported or documented by physician, or someone working under physician's orders for any pregnancy. Document: Diagnosis and name of the physician that is treating this condition in the participant's health record.	I

BREASTFEEDING WOMEN		
CODE		PRIORITY
304	HISTORY OF PREECLAMPSIA History of diagnosed preeclampsia Presence of condition diagnosed by a physician as self-reported by applicant/participant/caregiver; or as reported or documented by physician, or someone working under physician's orders for any pregnancy. Document: Diagnosis and name of the physician that is treating this condition in the participant's health record.	I
311	DELIVERY OF PREMATURE INFANT(S) Woman has delivered one (1) or more infants at 37 weeks gestation or less. Applies to most recent pregnancy only. Document: Delivery date and weeks gestation in participant's health record	I
312	DELIVERY OF LOW BIRTH WEIGHT INFANT(S) Woman has delivered one (1) or more infants with a birth weight of less than or equal to 5 lb. 8 oz. (2500 g). Applies to most recent pregnancy only. Document: Weight(s) and birth date in the participant's health record	I
321	HISTORY OF SPONTANEOUS ABORTION, FETAL OR NEONATAL LOSS Most recent pregnancy in which there was a multifetal gestation with one or more fetal or neonatal deaths but with one or more infants still living. This does not include elective abortions. Document: Date(s) of spontaneous abortion(s) or fetal/neonatal death(s) in the participant's health record; weeks gestation for spontaneous abortion; weeks gestation for fetal death(s); age, at death, of neonate(s).	I

BREASTFEEDING WOMEN		
CODE		PRIORITY
331	PREGNANCY AT A YOUNG AGE For most recent pregnancy, Conception at less than or equal to 17 years of age. Applies to most recent pregnancy only. Document: Age at conception on the WIC Assessment/Certification Form High Risk: Conception at less than or equal to 17 years of age	I
332	SHORT INTERPREGNANCY INTERVAL Delivery date for most recent pregnancy occurred less than 25 months after the live birth of the previous pregnancy. Document: Delivery dates of last two pregnancies in the participant's health record.	I
333	HIGH PARITY AND YOUNG AGE The following two (2) conditions must both apply: 1. The woman is under age 20 at date of conception AND 2. She has had 3 or more pregnancies of at least 20 weeks duration (regardless of birth outcome), previous to the most recent pregnancy. Document: Delivery date; number of pertinent previous pregnancies (of at least 20 weeks gestation) and weeks gestation for each, in the participant's health record.	I
335	MULTI FETAL GESTATION More than one (>1) fetus in the most recent pregnancy High Risk: Multi-fetal gestation	I
337	HISTORY OF A LARGE FOR GESTATIONAL AGE INFANT Most recent pregnancy, or history of giving birth to an infant with a birth weight of 9 pounds or more. Document: Birth weight(s) and date(s) of deliveries in the participant's health record.	I

BREASTFEEDING WOMEN		
CODE		PRIORITY
339	BIRTH WITH NUTRITION RELATED CONGENITAL OR BIRTH DEFECT(S) A woman who gives birth to an infant who has a congenital or birth defect linked to inappropriate nutritional intake, e.g., inadequate zinc, folic acid (neural tube defect), excess vitamin A (cleft palate or lip). Applies to most recent pregnancy only. Document: Infant(s) congenital and/or birth defect(s) in participant's health record	I
NUTRITION RELATED MEDICAL CONDITIONS		I
341	NUTRIENT DEFICIENCY DISEASES Diagnosis of clinical signs of nutritional deficiencies or a disease caused by insufficient dietary intake of macro or micro nutrients. Diseases include, but not limited to: protein energy malnutrition, hypocalcemia, cheilosis, scurvy, osteomalacia, menkes disease, rickets, Vitamin K deficiency, xerothalmia, beriberi, and pellagra. (See Appendix C) The presence of nutrient deficiency diseases diagnosed by a physician as self-reported by applicant/participant/caregiver; or as reported or documented by a physician, or a health professional acting under standing orders of a physician. Document: Diagnosis and name of the physician that is treating this condition in participant's health record. High Risk: Diagnosed nutrient deficiency disease	

BREASTFEEDING WOMEN		
CODE		PRIORITY
352	INFECTIOUS DISEASES **Acute Infectious Diseases:** A disease which is characterized by a single or repeated episode of relatively rapid onset and short duration. Acute infectious diseases include, but are not limited to: Hepatitis A, Hepatitis E, Meningitis (Bacterial/Viral), Parasitic Infections, Listeriosis, Pneumonia, Bronchitis (3 episodes) The acute infectious disease must be present within the past 6 months. Document: Diagnosis, appropriate dates of each occurrence, and name of physician treating condition in the participant's health record.	I
	Chronic Infectious Diseases: Conditions likely lasting a lifetime and require long-term management of symptoms. Chronic infectious diseases include, but are not limited to: HIV/AIDS, Hepatitis D, Hepatitis B, and Hepatitis C. Document: Diagnosis and name of physician treating condition in the participant's health record. When using HIV/AIDS positive status as a Nutritionally Related Medical Condition, write "See Medical Record" for documentation purpose. High Risk: Diagnosed infectious disease, as described above	
353	FOOD ALLERGIES An adverse immune response to a food or a hypersensitivity that causes adverse immunologic reaction. Presence of condition diagnosed, documented, or reported by a physician or someone working under a physician's orders, or as self-reported by applicant/participant/caregiver. Document: Diagnosis and name of the physician that is treating this condition in participant's health record. High Risk: Diagnosed food allergy	I

BREASTFEEDING WOMEN		
CODE		PRIORITY
354	CELIAC DISEASE Also known as Celiac Sprue, Gluten Enteropathy, or Non-tropical Sprue. Inflammatory condition of the small intestine precipitated by the ingestion of wheat in individuals with certain genetic make-up. Presence of condition diagnosed, documented, or reported by a physician or someone working under a physician's orders, or as self-reported by applicant/participant/caregiver. Document: Diagnosis and name of the physician that is treating this condition in participant's health record. High Risk: Diagnosed Celiac Disease	I
355	LACTOSE INTOLERANCE Lactose intolerance occurs when there is an insufficient production of the enzyme lactase. Lactase is needed to digest lactose. Lactose in dairy products that is not digested or absorbed is fermented in the small intestine producing any or all of the following GI disturbances: nausea, diarrhea, abdominal bloating, cramps. Lactose intolerance varies among and within individuals and ranges from mild to severe. Presence of condition diagnosed, documented, or reported by a physician or someone working under a physician's orders, or as self-reported by applicant/participant/caregiver. Document: Diagnosis and the name of the physician that is treating this condition in the participant's health record; OR list of symptoms described by the applicant/participant/caregiver (i.e., nausea, cramps, abdominal bloating, and/or diarrhea).	I

BREASTFEEDING WOMEN		
CODE		PRIORITY
372	ALCOHOL AND ILLEGAL DRUG USE Alcohol use: • Routine current use of ≥ 2 drinks per day OR • Binge drinking is defined as ≥5 drinks on the same occasion on at least one day in the past 30 days, OR • Heavy drinking is defined as ≥5 drinks on the same occasion on five or more days in the past 30 days A serving of standard sized drink (1 ½ ounce of alcohol) is: - 1 can of beer (12 fluid oz..) - 5 oz.. wine - 1 ½ fluid oz.. liquor Document: Alcohol Use; identify type (Routine - Enter oz../wk.: ___, Binge drinker, Heavy drinker) on WIC Assessment/Certification Form. See Appendix D for documentation codes.	I
	Any Illegal drug use: Document: Type of drug(s) being used.	
381	ORAL HEALTH Diagnosis of oral health conditions diagnosed, documented, or reported by a physician, dentist, or someone working under a physician's orders, or as self-reported by applicant/participant/caregiver. • Dental Caries • Periodontal Disease – Gingivitis or periodontitis • Tooth Loss - ineffectively replaced teeth or oral infections which impair the ability to ingest food in adequate quantity or quality. Document: Oral Health Condition and name of physician, dentist or someone working under a doctor's orders that is treating this condition in the participant's health record.	I

BREASTFEEDING WOMEN		
CODE		PRIORITY
400	INAPPROPRIATE NUTRITION PRACTICES Routine nutrition practices that may result in impaired nutrient status, disease, or health problems. (Appendix E) Document: Inappropriate Nutrition Practice(s) in the participant's health record.	IV
401	FAILURE TO MEET DIETARY GUIDELINES A woman who meets eligibility requirements based on category, income, and residency but who does not have any other identified nutritional risk factor may be presumed to be at nutritional risk based on failure to meet the *Dietary Guidelines for Americans*. (This risk factor may be assigned only when a woman does not qualify for risk 400 or for any other risk factor.)	IV
502	TRANSFER OF CERTIFICATION Person with a current valid Verification of Certification (VOC) document from another state or local agency. The VOC is valid until the certification period expires, and shall be accepted as proof of eligibility for Program benefits. If the receiving local agency has waiting lists for participation, the transferring participant shall be placed on the list ahead of all other waiting applicants. This criterion should be used primarily when the VOC card/document does not reflect another more specific nutrition risk condition at the time of transfer or if the participant was initially certified based on a nutrition risk condition not in use by the receiving agency.	I, II, IV
601	BREASTFEEDING MOTHER OF AN INFANT AT NUTRITIONAL RISK A breastfeeding woman whose breastfed infant has been determined to be at nutritional risk. Document: Infant's risks on mother's WIC Assessment/Certification Form.	I, II, IV

POSTPARTUM NON-BREASTFEEDING WOMEN

CODE		PRIORITY
133	HIGH MATERNAL WEIGHT GAIN Non-Breastfeeding (most recent pregnancy only): total gestational weight gain exceeding the upper limit of the recommended range based on Body Mass Index (BMI), as follows: Prepregnancy Weight Group / Definition (BMI) / Cut-off Value (Singleton) / Cut-off Value (Multi-Fetal) Underweight / < 18.5 / >40 lbs. / * Normal Weight / 18.5 to 24.9 / >35 lbs. / >54 lbs. Overweight / 25.0 to 29.9 / >25 lbs. / >50 lbs. Obese / ≥ 30.0 / >20 lbs. / >42 lbs. *There are no provisional guidelines for underweight woman with multiple fetuses. (Appendix B-2) Document: Pre-gravid weight and last weight before delivery	VI
211	ELEVATED BLOOD LEAD LEVELS Blood lead level of ≥ 5 μg/deciliter within the past 12 months. Document: Date of blood test and blood lead level in the participant's health record. Must be within the past 12 months. High Risk: Blood lead level of ≥ 5 μg/deciliter within the past 12 months.	VI
303	HISTORY OF GESTATIONAL DIABETES History of diagnosed gestational diabetes mellitus (GDM) Presence of condition diagnosed by a physician as self-reported by applicant/participant/caregiver; or as reported or documented by physician, or someone working under physician's orders for any pregnancy. Document: Diagnosis and name of the physician that is treating this condition in the participant's health record.	VI

POSTPARTUM NON-BREASTFEEDING WOMEN		
CODE		PRIORITY
304	HISTORY OF PREECLAMPSIA History of diagnosed preeclampsia Presence of condition diagnosed by a physician as self-reported by applicant/participant/caregiver; or as reported or documented by physician, or someone working under physician's orders for any pregnancy. Document: Diagnosis and name of the physician that is treating this condition in the participant's health record.	VI
311	DELIVERY OF PREMATURE INFANT(S) Woman has delivered one (1) or more infants at 37 weeks gestation or less. Applies to most recent pregnancy only. Document: Delivery date and weeks gestation in participant's health record	VI
312	DELIVERY OF LOW BIRTH WEIGHT INFANT(S) Woman has delivered one (1) or more infants with a birth weight of less than or equal to 5 lb. 8 oz.. (2500 gms). Applies to most recent pregnancy only. Document: Weight(s) and birth date in the participant's health record.	VI
321	HISTORY OF SPONTANEOUS ABORTION, FETAL OR NEONATAL LOSS A spontaneous abortion (death < 20 weeks gestation), fetal death (death $\geq$ 20 weeks gestation) or a neonatal death (death occurring from 0-28 days of life). Applies to most recent pregnancy only. This does not include elective abortions. Document: Date(s) of spontaneous abortion, fetal/neonatal death(s) in the participant's health record; weeks gestation of spontaneous abortion; weeks gestation for fetal death(s); age, at death, of neonate(s).	VI

POSTPARTUM NON-BREASTFEEDING WOMEN		
CODE		PRIORITY
331	PREGNANCY AT A YOUNG AGE For most recent pregnancy. Conception at less than or equal to 17 years of age. Applies to most recent pregnancy only. Document: Age at conception on the WIC Assessment/Certification Form High Risk: Conception at less than or equal to 17 years of age	III
332	SHORT INTERPREGNANCY INTERVAL Delivery date for most recent pregnancy occurred less than 25 months after the live birth of the previous pregnancy. Document: Delivery dates of last two pregnancies in the participant's health record.	VI
333	HIGH PARITY AND YOUNG AGE The following two (2) conditions must both apply: 1. The woman is under age 20 at date of conception AND 2. She has had 3 or more pregnancies of at least 20 weeks duration (regardless of birth outcome), previous to the most recent pregnancy. Document: Delivery date; number of pertinent previous pregnancies (of at least 20 weeks gestation) and weeks gestation for each, in the participant's health record	VI
335	MULTI FETAL GESTATION More than one (>1) fetus in the most recent pregnancy High Risk: Multi-fetal gestation	VI

POSTPARTUM NON-BREASTFEEDING WOMEN		
CODE		Priority
337	HISTORY OF A LARGE FOR GESTATIONAL AGE INFANT Most recent pregnancy, or history of giving birth to an infant with a birth weight of 9 pounds or more. Document: Birth weight(s) and date(s) of deliveries in the participant's health record.	VI
339	BIRTH WITH NUTRITION RELATED CONGENITAL OR BIRTH DEFECT(S) A woman who gives birth to an infant who has a congenital or birth defect linked to inappropriate nutritional intake, e.g., inadequate zinc, folic acid (neural tube defect) , excess vitamin A (cleft palate or lip). Applies to most recent pregnancy only. Document: Infant(s) congenital and/or birth defect(s) in the participant's health record.	VI
NUTRITION RELATED MEDICAL CONDITIONS		VI
341	NUTRIENT DEFICIENCY DISEASES Diagnosis of clinical signs of nutritional deficiencies or a disease caused by insufficient dietary intake of macro or micro nutrients. Diseases include, but not limited to: protein energy malnutrition, hypocalcemia, cheilosis, scurvy, osteomalacia, menkes disease, rickets, Vitamin K deficiency, xerothalmia, beriberi, and pellagra. (See Appendix C) The presence of nutrient deficiency diseases diagnosed by a physician as self-reported by applicant/participant/caregiver; or as reported or documented by a physician, or a health professional acting under standing orders of a physician. Document: Diagnosis and the name of the physician that is treating this condition in participant's health record. High Risk: Diagnosed nutrient deficiency disease	

POSTPARTUM NON-BREASTFEEDING WOMEN		
CODE		PRIORITY
352	INFECTIOUS DISEASES **Acute Infectious Diseases:** A disease which is characterized by a single or repeated episode of relatively rapid onset and short duration. Acute infectious diseases include, but are not limited to: Hepatitis A, Hepatitis E, Meningitis (Bacterial/Viral), Parasitic Infections, Listeriosis, Pneumonia, Bronchitis (3 episodes) The acute infectious disease must be present within the past 6 months. Document: Diagnosis, appropriate dates of each occurrence, and name of physician treating condition in the participant's health record.	VI
	Chronic Infectious Diseases: Conditions likely lasting a lifetime and require long-term management of symptoms. Chronic infectious diseases include, but are not limited to: HIV/AIDS, Hepatitis D, Hepatitis B, and Hepatitis C. Document: Diagnosis and name of physician treating condition in the participant's health record. When using HIV/AIDS positive status as a Nutritionally Related Medical Condition, write "See Medical Record" for documentation purpose. High Risk: Diagnosed infectious disease, as described above	
353	FOOD ALLERGIES An adverse immune response to a food or a hypersensitivity that causes adverse immunologic reaction. Presence of condition diagnosed, documented, or reported by a physician or someone working under a physician's orders, or as self-reported by applicant/participant/caregiver. Document: Diagnosis and the name of the physician that is treating this condition. High Risk: Diagnosed food allergy	VI

POSTPARTUM NON-BREASTFEEDING WOMEN		
CODE		PRIORITY
354	CELIAC DISEASE Also known as Celiac Sprue, Gluten Enteropathy, or Non-tropical Sprue. Inflammatory condition of the small intestine precipitated by the ingestion of wheat in individuals with certain genetic make-up. Presence of condition diagnosed, documented, or reported by a physician or someone working under a physician's orders, or as self-reported by applicant/participant/caregiver. Document: Diagnosis and the name of the physician that is treating this condition. High Risk: Diagnosed Celiac Disease	VI
355	LACTOSE INTOLERANCE Lactose intolerance occurs when there is an insufficient production of the enzyme lactase. Lactase is needed to digest lactose. Lactose in dairy products that is not digested or absorbed is fermented in the small intestine producing any or all of the following GI disturbances: nausea, diarrhea, abdominal bloating, cramps. Lactose intolerance varies among and within individuals and ranges from mild to severe. Presence of condition diagnosed, documented, or reported by a physician or someone working under a physician's orders, or as self-reported by applicant/participant/caregiver. Document: Diagnosis and the name of the physician that is treating this condition in the participant's health record; OR list of symptoms described by the applicant/participant/caregiver (i.e., nausea, cramps, abdominal bloating, and/or diarrhea).	VI

INFANTS		
CODE		PRIORITY
121	SHORT STATURE OR AT RISK OF SHORT STATURE Less than or equal to the 5th percentile length-for-age as plotted on the CDC Birth to 24 months gender specific growth charts.* (if < 38 weeks gestation use adjusted age) High Risk: Less than or equal to the 2nd percentile length-for-age when manually plotted on the Centers for Disease Control and Prevention (CDC) Birth to 24 months gender specific growth charts.* Less than or equal to the 2.3rd percentile length-for-age when electronically plotted on the Centers for Disease Control and Prevention (CDC) Birth to 24 months gender specific growth charts.* **Based on 2006 World Health Organization international growth standard. CDC labels the 2.3rd percentile as the 2nd percentile on the Birth to 24 months gender specific growth charts.*	I
134	FAILURE TO THRIVE Presence of failure to thrive diagnosed by a physician or health professional acting under standing orders of a physician. Document: Diagnosis and the name of the physician that is treating this condition in the participant's health record High Risk: Diagnosed failure to thrive	I

<table>
<tr><th colspan="3">INFANTS</th></tr>
<tr><th>CODE</th><th></th><th>PRIORITY</th></tr>
<tr><td>135</td><td>SLOWED/FALTERING GROWTH PATTERN
(Infants ≤ 2 weeks of Age)

Infants birth to 2 weeks of age with weight loss after birth of ≥ 7% birth weight.

<table>
<tr><th>Assign Risk When Birth Weight Is :</th><th>And Weight Loss Is ≥ :</th></tr>
<tr><td>4 lbs. 0 oz. – 4 lbs. 16 oz.</td><td>5 oz.</td></tr>
<tr><td>4 lbs. 15 oz. – 5 lbs. 12 oz.</td><td>6 oz.</td></tr>
<tr><td>5 lbs. 13 oz.– 6 lbs. 10 oz.</td><td>7 oz.</td></tr>
<tr><td>6 lbs. 11 oz. – 7 lbs. 8 oz.</td><td>8 oz.</td></tr>
<tr><td>7 lbs. 9 oz. – 8 lbs. 6 oz.</td><td>9 oz.</td></tr>
<tr><td>8 lbs. 7 oz. – 9 lbs. 5 oz.</td><td>10 oz.</td></tr>
<tr><td>9 lbs. 6 oz. – 10 lbs. 3 oz.</td><td>11 oz.</td></tr>
<tr><td>10 lbs. 4 oz. – 11 lbs. 2 oz.</td><td>12 oz.</td></tr>
</table>
</td><td>I</td></tr>
<tr><td></td><td>SLOWED/FALTERING GROWTH PATTERN
(Infants 2 weeks of Age to 6 months of Age)

Infants 2 weeks of age to 6 months of age with any weight loss. Use two separate weight measurements taken at least eight weeks apart.

High Risk: Slowed/Faltering Growth Pattern</td><td></td></tr>
<tr><td>141</td><td>LOW BIRTH WEIGHT

Birth weight ≤ 5 lbs. 8 oz. (≤ 2500 g)

Document: Birth weight in participant’s health record

High Risk: Birth weight ≤ 5 lbs. 8 oz. (≤ 2500 g)</td><td>I</td></tr>
</table>

INFANTS		
CODE		PRIORITY
142	PREMATURITY Infant born at ≤ 37 weeks gestation Document: Weeks gestation in participant's health record	I
151	Small for Gestational Age Infants diagnosed as small for gestational age. Presence of condition diagnosed, documented, or reported by a physician or someone working under a physician's orders, or as self-reported by applicant/participant/caregiver.	I
152	Low Head Circumference Less than 2nd percentile head circumference-for-age when manually plotted on the Centers for Disease Control and Prevention (CDC) Birth to 24 months gender specific growth charts* (if < 38 weeks gestation use adjusted age) Less than 2.3rd percentile head circumference-for-age when electronically plotted on the Centers for Disease Control and Prevention (CDC) Birth to 24 months gender specific growth charts* (if < 38 weeks gestation use adjusted age) ** Based on 2006 World Health Organization international growth standards. CDC labels the 2.3rd percentile as the 2nd percentile on the Birth to 24 months gender specific growth charts.*	I
153	LARGE FOR GESTATIONAL AGE Birth weight ≥ 9 lbs. or presence of large for gestational age diagnosed by a physician as self-reported by applicant/participant/caregiver; or as reported or documented by a physician, or health care professional working under standing orders of a physician. Document: Weight(s) of infant in participant's health record.	I

INFANTS	
CODE	PRIORITY
211 ELEVATED BLOOD LEAD LEVELS Blood lead level of ≥ 5 μg/deciliter within the past 12 months. Document: Date of blood test and blood lead level in participant's health record. Must be within the past 12 months High Risk: Blood lead level of ≥ 5 μg/deciliter within the past 12 months.	I
NUTRITION RELATED MEDICAL CONDITIONS 341 NUTRIENT DEFICIENCY DISEASES Diagnosis of clinical signs of nutritional deficiencies or a disease caused by insufficient dietary intake of macro or micro nutrients. Diseases include, but not limited to: protein energy malnutrition, hypocalcemia, cheilosis, scurvy, osteomalacia, menkes disease, rickets, Vitamin K deficiency, xerothalmia, beriberi, and pellagra. (See Appendix C) Presence of nutrient deficiency diseases diagnosed by a physician as self-reported by caregiver; or as reported or documented by a physician, or health professional acting under standing orders of a physician. Document: Diagnosis and the name of the physician that is treating this condition in the participant's health record High Risk: Diagnosed nutrient deficiency disease	I

INFANTS		
CODE		PRIORITY
352	INFECTIOUS DISEASES **Acute Infectious Diseases:** A disease which is characterized by a single or repeated episode of relatively rapid onset and short duration. Acute infectious diseases include, but are not limited to: Hepatitis A, Hepatitis E, Meningitis (Bacterial/Viral), Parasitic Infections, Listeriosis, Pneumonia, Bronchitis (3 episodes) The acute infectious disease must be present within the past 6 months. Document: Diagnosis, appropriate dates of each occurrence, and name of physician treating condition in the participant's health record.	I
	Chronic Infectious Diseases: Conditions likely lasting a lifetime and require long-term management of symptoms. Chronic infectious diseases include, but are not limited to: HIV/AIDS, Hepatitis D, Hepatitis B, and Hepatitis C. Document: Diagnosis and name of physician treating condition in the participant's health record. When using HIV/AIDS positive status as a Nutritionally Related Medical Condition, write "See Medical Record" for documentation purpose. High Risk: Diagnosed infectious disease, as described above	
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INFANTS		
CODE		PRIORITY
354	CELIAC DISEASE Also known as Celiac Sprue, Gluten Enteropathy, or Non-tropical Sprue. Inflammatory condition of the small intestine precipitated by the ingestion of wheat in individuals with certain genetic make-up. Presence of condition diagnosed, documented, or reported by a physician or someone working under a physician's orders, or as self-reported by applicant/participant/caregiver. Document: Diagnosis and the name of the physician that is treating this condition in the participant's health record. High Risk: Diagnosed Celiac Disease	I
355	LACTOSE INTOLERANCE Lactose intolerance occurs when there is an insufficient production of the enzyme lactase. Lactase is needed to digest lactose. Lactose in dairy products that is not digested or absorbed is fermented in the small intestine producing any or all of the following GI disturbances: nausea, diarrhea, abdominal bloating, cramps. Lactose intolerance varies among and within individuals and ranges from mild to severe. Presence of condition diagnosed, documented, or reported by a physician or someone working under a physician's orders, or as self-reported by applicant/participant/caregiver. Document: Diagnosis and the name of the physician that is treating this condition in the participant's health record; OR list of symptoms described by the applicant/participant/caregiver (i.e., nausea, cramps, abdominal bloating, and/or diarrhea).	I

CHILDREN		
CODE		PRIORITY
141	LOW BIRTH WEIGHT (children < 24 months of age) Birth weight ≤ 5 lbs. 8 oz. (≤ 2500 g) Document: Birth weight of participant in health record.	III
142	PREMATURITY (Children < 24 months of age) Born at 37 weeks gestation or less Document: Weeks gestation in participant's health record.	III
151	Small for Gestational Age (Children 12-24 Months of Age) Children less than 24 months of age diagnosed as small for gestational age. Presence of condition diagnosed, documented, or reported by a physician or someone working under a physician's orders, or as self-reported by applicant/participant/caregiver.	III

CHILDREN	
CODE	PRIORITY
152 Low Head Circumference (Children 12-24 Months of Age) Less than 2nd percentile head circumference-for-age as when manually plotted on the Centers for Disease Control and Prevention (CDC) Birth to 24 months gender specific growth charts (if < 38 weeks gestation use adjusted age) Less than 2.3rd percentile head circumference-for-age as when electronically plotted on the Centers for Disease Control and Prevention (CDC) Birth to 24 months gender specific growth charts (if < 38 weeks gestation use adjusted age) ** Based on 2006 World Health Organization international growth standards. CDC labels the 2.3rd percentile as the 2nd percentile on the Birth to 24 months gender specific growth charts.*	III
211 ELEVATED BLOOD LEAD LEVELS Blood lead level of $\geq$ 5 μg/deciliter within the past 12 months. Document: Date of blood test and blood lead level in participant's health record. Must be within the past 12 months. High Risk: Blood lead level of $\geq$ 5 μg/deciliter within the past 12 months.	III
NUTRITION RELATED MEDICAL CONDITIONS 341 NUTRIENT DEFICIENCY DISEASES Diagnosis of clinical signs of nutritional deficiencies or a disease caused by insufficient dietary intake of macro or micronutrients. Diseases include, but not limited to: protein energy malnutrition, hypocalcemia, cheilosis, scurvy, osteomalacia, menkes disease, rickets, Vitamin K deficiency, xerothalmia, beriberi, and pellagra. (See Appendix C) Presence of nutrient deficiency diseases diagnosed by a physician as self-reported by caregiver; or as reported or documented by a physician, or health professional acting under standing orders of a physician. Document: Diagnosis and name of the physician that is treating this condition participant's health record. High Risk: Diagnosed nutrient deficiency disease	III

CHILDREN		
CODE		PRIORITY
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CHILDREN		
CODE		PRIORITY
354	CELIAC DISEASE Also known as Celiac Sprue, Gluten Enteropathy, or Non-tropical Sprue. Inflammatory condition of the small intestine precipitated by the ingestion of wheat in individuals with certain genetic make-up. Presence of condition diagnosed, documented, or reported by a physician or someone working under a physician's orders, or as self-reported by applicant/participant/caregiver. Document: Diagnosis and name of the physician that is treating this condition in the participant's health record. High Risk: Diagnosed Celiac Disease	III
355	LACTOSE INTOLERANCE Lactose intolerance occurs when there is an insufficient production of the enzyme lactase. Lactase is needed to digest lactose. Lactose in dairy products that is not digested or absorbed is fermented in the small intestine producing any or all of the following GI disturbances: nausea, diarrhea, abdominal bloating, cramps. Lactose intolerance varies among and within individuals and ranges from mild to severe. Presence of condition diagnosed, documented, or reported by a physician or someone working under a physician's orders, or as self-reported by applicant/participant/caregiver. Document: Diagnosis and the name of the physician that is treating this condition in the participant's health record; OR list of symptoms described by the applicant/participant/caregiver (i.e., nausea, cramps, abdominal bloating, and/or diarrhea).	III

TABLE OF APPENDICES
APPENDICES REFERENCED IN RISK CRITERIA SECTION

WOMEN'S HEALTH
RECOMMENDED GUIDELINES FOR IRON SUPPLEMENTATION
BASED ON TREATMENT VALUES

	Hemoglobin Treatment Value		Hematocrit Treatment Value	
	Non-Smokers	Smokers	Non-Smokers	Smokers
Prenatal Woman 1st Trimester 3rd Trimester	<11.0 gm	<11.3 gm	<33.0%	<34.0%
Prenatal Woman 2nd Trimester	<10.5 gm	<10.8 gm	<32.0%	<33.0%
Non-Pregnant and/or Lactating Woman (<15 years of age)	<11.8 gm	<12.1 gm	<35.7%	<36.7%
Non-Pregnant and/or Lactating Woman (≥15 years of age)	<12.0 gm	<12.3 gm	<35.7%	<36.7%

PHYSICIAN REFERRAL:

- Hemoglobin less than 9.0 g/dL or hematocrit less than 27.0%
- Hemoglobin more than 15.0 g/dL or hematocrit more than 45.0% (2nd and 3rd trimester)
- If after 4 weeks the hemoglobin does not increase by 1 g/dL or hematocrit by 3%, despite compliance with iron supplementation regimen and the absence of acute illness

In 2006, the U.S. Preventive Services Task Force released a Recommendation Statement that states that the American College of Obstetricians and Gynecologists (ACOG) recommends screening and treatment based on low Hemoglobin results. ACOG does not recommend routine supplementation for pregnant women at this time.

References:

CDC/MMWR: April 3, 1998. Recommendations to Prevent and Control Iron Deficiency in the United States (*current April 20, 2015*)

Final Recommendation Statement: Iron Deficiency Anemia: Screening. U.S. Preventive Services Task Force. May 2006.
http://www.uspreventiveservicestaskforce.org/Page/Document/RecommendationStatementFinal/iron-deficiency-anemia-screening

CHILD HEALTH RECOMMENDED GUIDELINES
FOR IRON SUPPLEMENTATION
BASED ON TREATMENT VALUES

	Hemoglobin Treatment Value	Hematocrit Treatment Value	Treatment Regimen
Infant 6 through 11 months	<11.0	<33.0%	Dosage: 0.6 cc Ferrous Sulfate Drops BID Mg Elemental Iron: 15 mg BID
Child 12 through 23 months	<11.0	<32.9%	Dosage: 0.6 cc Ferrous Sulfate Drops BID Mg Elemental Iron: 15 mg BID
Child 2 through 5 years	<11.1	<33.0%	Dosage: 1.2 cc Ferrous Sulfate Drops BID Mg Elemental Iron: 30mg BID

- Premature and low birth weight infants, infants of multiple births, and infants with suspected blood losses should be screened before 6 months of age, preferably at 6-8 weeks postnatal.
- Routine screening for iron deficiency anemia is not recommended in the first 6 months of life.
- Treatment of iron deficiency anemia is 3-6 mg per kilogram per day.
- Refer to the package insert of iron preparation to correctly calculate the appropriate dosage of elemental iron. Most pediatric chewable preparations (i.e., Feostat, 100 mg) contain 33 mg elemental iron per tablet as ferrous fumarate. Non-chewable preparations for older patients (i.e., Feosol, 300 mg) contain 60-65 mg per tablet or capsule elemental iron as ferrous sulfate.
- The doses for the liquid product referred to in the chart are based on the solution concentration of 15mg/0.6ml.

Sources: Centers for Disease Control and Prevention, *Morbidity and Mortality Weekly Report*, April 3, 1998/Vol.47/No. RR-3 (current April 20, 2015).

Georgia Department of Public Health, Nurse Protocols for Registered Professional Nurses 2014, *Standard Nurse Protocol for Prevention and Treatment of Iron Deficiency with or without Anemia,* Child Health 8.73.

Definition of Weight Gain (Women)

Total Weight Gain Range (lbs.)

Singleton Pregnancy

Pre-pregnancy Weight Groups	Definition (BMI)	Low Maternal Weight Gain	Recommended Weight Gain	High Maternal Weight Gain
Underweight	< 18.5	<28	28-40	> 40
Normal Weight	18.5 to 24.9	<25	25-35	> 35
Overweight	25.0 to 29.9	<15	15-25	> 25
Obese	≥ 30.0	<11	11-20	> 20

Multi-Fetal Weight Gain

Pre-pregnancy Weight Groups	Definition (BMI)	Low Maternal Weight Gain	Recommended Weight Gain	High Maternal Weight Gain
Underweight	< 18.5	There was insufficient information for the IOM committee to develop provisional guidelines for underweight woman with multiple fetuses.	1.5lbs./week during 2nd and 3rd trimesters	There was insufficient information for the IOM committee to develop provisional guidelines for underweight woman with multiple fetuses.
Normal Weight	18.5 to 24.9	<37	37-54	> 54
Overweight	25.0 to 29.9	<31	31-50	> 50
Obese	≥ 30.0	<25	25-42	> 42

As you work with counseling morbidly obese pregnant participants, please be aware that American Congress of Obstetricians and Gynecologists, has opined that careful consideration of weight gain based on a holistic assessment of the mother and baby is necessary as these are only general recommendations. This does not impact the selection of the appropriate risk factors and growth charts for evaluation. It does mean that your counseling should be informed by a total evaluation of the participant's status including an awareness of what the participant is being told by their physician.

Reference: Institute of Medicine. Weight gain during pregnancy: reexamining the guidelines. National Academy Press, Washington, D.C., 2009. http://www.iom.edu/en/Reports/2009/Weight-Gain-During-Pregnancy-Reexamining-the-Guidelines.aspx Reviewed March 18, 2015.

Reference: American Congress of Obstetricians and Gynecologists: Committee Opinion: Weight Gain in Pregnancy. Number 548, January 2013. http://www.acog.org/Resources-And-Publications/Committee-Opinions/Committee-on-Obstetric-Practice/Weight-Gain-During-Pregnancy accessed April 7, 2015.

PHYSICAL SIGNS SUGGESTIVE OF NUTRIENT DEFICIENCIES

Body Area	Normal Appearance	Signs Suggestive of Nutrient Deficiency(ies)	Nutrient Consideration(s)
Hair	shiny; firm; not easily plucked	lack of natural shine; dull; thin; loss of curl; color changes (flag sign); easily plucked	inadequate protein and calories
Eyes	bright; clear; shiny; no sores at corners of eyelids;	eye membranes pale;	anemia (inadequate iron, folacin, or vitamin B-12)
	membranes healthy pink and moist; no prominent blood vessels	Bitot's spots; red membranes; dryness of membranes; dull appearance of cornea (cornea xerosis); softening of cornea (keratomalacia);	inadequate Vitamin A
		redness and fissuring of eyelid corners	inadequate riboflavin, Vitamin B-6, and niacin
Lips	smooth; not chapped or swollen	redness or swelling of mouth or lips (cheilosis);	inadequate niacin and riboflavin
		bilateral cracks, white or pink lesions at corners of mouth (angular stomatitis) and/or scars	inadequate riboflavin, niacin, iron and Vitamin B-6
Gums	healthy, red; do not bleed; not swollen	spongy; bleeding; receding	inadequate ascorbic acid
Tongue	deep red; not swollen or smooth	scarlet; raw; edematous (glossitis)	inadequate niacin, riboflavin, folacin, iron, Vitamins B-6 and B-12
		purplish color (magenta);	inadequate riboflavin
		smooth; pale; slick; atrophied taste buds (papillae)	inadequate folacin, Vitamin B-12, iron and niacin
Face and Neck	skin color uniform, smooth, pink; healthy appearing; not swollen	diffuse depigmentation;	inadequate protein
		darkening of skin over cheeks and under eyes;	inadequate calories and niacin
		scaling of skin around nostrils (nasolabial seborrhea)	inadequate riboflavin, niacin, and Vitamin B-6
		swollen (moon) face;	inadequate protein
		front of neck swollen (thyroid enlargement);	inadequate protein; inadequate iodine
		swollen cheeks (bilateral parotid enlargement)	inadequate protein

PHYSICAL SIGNS SUGGESTIVE OF NUTRIENT DEFICIENCIES

Body Area	Normal Appearance	Signs Suggestive of Nutrient Deficiency(ies)	Nutrient Consideration(s)
Skin	no signs of swelling rashes, dark or light spots	dry and scaly (xerosis); sandpaper-like feel (follicular hyperkeratosis);	Inadequate Vitamin A or Essential fatty acids
		pinhead-size purplish skin hemorrhages (petechiae);	Inadequate Vitamin C
		excessive bruising;	Inadequate Vitamin K
		red, swollen pigmentation of areas exposed to sunlight (pellagrous dermatitis);	Inadequate niacin and Tryptophan
		extensive lightness and darkness of skin (flaky, pressure sores(decubiti)	Inadequate protein, Vitamin C, and zinc
Teeth	no cavities, no pain, bright	may be some missing or erupting abnormally; gray or black spots (fluorosis); cavities (caries) [signs are to be severe enough to interfere with mastication and/or other health implications]*	Inadequate Vitamin D and Vitamin A
Head / Neck	face not swollen	thyroid enlargement (front of neck); parotid enlargement (cheeks become swollen)	Inadequate iodine; inadequate protein
Nails	firm, pink	nails are spoon-shaped (koilonychia); brittle ridged nails, pale nail beds	Inadequate iron; Vitamin A toxicity
Muscular and Skeletal Systems	good muscle tone; some fat under skin; can walk or run without pain	muscles have "wasted" appearance; baby's skull bones are thin and soft (craniotabes); round swelling of front and side of head (frontal and parietal bossing); swelling of ends of bones (epiphyseal enlargement); small bumps on both sides of chest wall (on ribs); beading of ribs; baby's soft spot on head does not harden at proper time (persistently open anterior fontanelle); knock-knees or bow-legs; bleeding into muscle (musculoskeletal hemorrhages); person cannot get up or walk properly	Inadequate protein Inadequate thiamin Inadequate Vitamin D

Sources: 1. American Journal of Public Health, Supplement, November 1973, p. 19.

2. Georgia Dietetic Association Diet Manual, 1992.

This page is currently under review and is continued in 2018 by district request.

Inappropriate Nutrition Practices for Children

Inappropriate Nutrition Practices for Children	Examples of Inappropriate Nutrition Practices (Including but not limited to)
Inappropriate beverages as primary milk source Routinely feeding inappropriate beverages as the primary milk source.	Examples of inappropriate beverages as primary milk source: • Non-fat or reduced-fat milks (between 12 and 24 months of age only) or sweetened condensed milk; and • Imitation or substitutes milks (such as inadequately or unfortified rice- or soy-based beverages, non-dairy creamer), or other "homemade concoctions."
Routinely feeding sugar-containing fluids Routinely feeding a child any sugar-containing fluids.	Examples of sugar-containing fluids: • Soda/soft drinks; • Gelatin water; • Corn syrup solutions; and • Sweetened tea.
Improper use of nursing bottles, cups, or pacifiers Routinely using nursing bottle, cups, or pacifiers improperly.	• Using a bottle to feed: ➢ Fruit juice, or ➢ Diluted cereal or other solid foods. • Allowing the child to fall asleep or be put to bed with a bottle at naps or bedtime. • Allowing the child to use the bottle without restriction (e.g., walking around with a bottle) or as a pacifier. • Using a bottle for feeding or drinking beyond 14 months of age. • Using a pacifier dipped in sweet agents such as sugar, honey, or syrups. • Allowing a child to carry around and drink, throughout the day, from covered or training cups.
Feeding practices that disregard development Routinely using feeding practices that disregard the developmental needs or stages of the child.	• Inability to recognize, insensitivity to, or disregarding the child's cues for hunger and satiety (e.g., forcing a child to eat a certain type and/or amount of food or beverage or ignoring a hungry child's request for appropriate foods). • Feeding foods of inappropriate consistency, size, or shape that put children at risk of choking. • Not supporting a child's need for growing independence with self-feeding (e.g.; solely spoon-feeding a child who is able and ready to finger-feed and/or try self-feeding with appropriate utensils). • Feeding a child with an inappropriate texture based on his/her developmental stage (e.g., feeding primarily purees or liquid food when the child is read and capable of eating mashed, chopped, or appropriate finger food).

Inappropriate Nutrition Practices for Children	Examples of Inappropriate Nutrition Practices (Including but not limited to)
Ingestion of potentially contaminated foods Feeding foods to a child that could be contaminated with harmful microorganisms.	Examples of potentially harmful foods for a child: • Unpasteurized fruit or vegetable juices. • Unpasteurized dairy products or soft cheese such as feta, Brie, Camembert, blue-veined cheeses and Mexican style cheese such as queso blanco, queso fresco, or Panela unless labeled as "made with pasteurized milk • Raw or undercooked meat, fish, poultry, or eggs • Raw sprouts (alfalfa, clover, and radish) • Hot dogs, luncheon meat (cold cuts), fermented and fry sausage and other deli-style meat or poultry unless reheated until steaming hot; • Undercooked, raw tofu
Diet very low in calories or essential nutrients Routinely feeding a diet very low in calories and/or essential nutrients.	Examples: • Vegan Diet; • Macrobiotic diet; and • Other diets very low in calories and/or essential nutrients.
Potentially harmful dietary supplements Feeding dietary supplements with potentially harmful consequences	Examples of dietary supplements which when feed in excess of recommended dosages, may be toxic or have harmful consequences: • Single or multiple vitamins • Mineral supplements; and • Herbal or botanical supplements/remedies/teas
Inadequate supplementation of essential vitamin/minerals Routinely not providing dietary supplements as recognized as essential by national public health policy when a child's diet alone cannot meet nutrient requirements.	• Providing children under 36 months of age less than 0.25 mg of fluoride daily when the water supply contains less than 0.3 ppm fluoride. • Providing children 36-60 months of age less than 0.50 mg of fluoride daily when the water contains less than 0.3 ppm fluoride. • Not providing 400 IU of vitamin D if a child consumes less than 1 liter (or 1 quart) of vitamin D fortified milk or formula.
Routine ingestion of non-food items (pica)	• Ashes; • Carpet fibers; • Cigarettes or cigarette butts; • Clay; • Dust; • Foam Rubber • Paint chips; • Soil; and • Starch (laundry and cornstarch)