Kansas WIC Program

Nutrition Risk Factors
Pregnant Women

Revised - September 16, 2019

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Risk Conditions marked with a check (✓) are considered high risk by the SA. LAs have the option of declaring any additional client as high risk by using “Professional Discretion High Risk”.

Risk Conditions marked with a computer mouse (✓) are auto-assigned by the KWIC system.

Risk Conditions marked with a computer mouse (✓) and asterisk (*) are auto-assigned by the KWIC system in situations when qualifying pertinent data exists in the KWIC system. However staff must assess and manually assign the risk factor if pertinent data is not part of the WIC record.

The definition for each Risk Condition is by followed the priority and the date the condition was last revised by the Risk Identification and Selection Collaborative.
Intake of Dietary Supplements with Potentially Harmful Effects
- Consuming inappropriate or excessive amounts of dietary supplements not prescribed by a physician. Including:
  - Single or multiple vitamins;
  - Mineral supplements; and
  - Herbal or botanical supplements/remedies/teas.

Diet Very Low in Calories and/or Essential Nutrients
- Consuming a diet very low in calories and/or essential nutrients; or impaired caloric intake or absorption of essential nutrients following bariatric surgery. Such as:
  - Strict vegan diet;
  - Low-carbohydrate, high-protein diet;
  - Macrobiotic diet; and
  - Any other diet restricting calories and/or essential nutrients.

Pica
- Compulsively ingesting non-food items. Such as:
  - Ashes;
  - Baking soda;
  - Burnt matches;
  - Carpet fibers;
  - Chalk;
  - Cigarettes;
  - Clay;
  - Dust;
  - Large quantities of ice and/or freezer frost;
  - Paint chips;
  - Soil; and
  - Starch (laundry and cornstarch).

Inadequate Vitamin/Mineral Supplementation
- Inadequate vitamin/mineral supplementation recognized as essential by national public health policy. Including:
  - Consumption of less than 27 mg of supplemental iron per day; and
  - Consumption of less than 150 μg of supplemental iodine per day.
Consuming Foods that Could be Contaminated

- Pregnant woman ingesting foods that could be contaminated with pathogenic microorganisms. Potentially harmful foods include:
  - Raw fish or shellfish, including oysters, clams, mussels, and scallops;
  - Refrigerated smoked seafood, unless it is an ingredient in a cooked dish, such as a casserole;
  - Raw or undercooked meat or poultry;
  - Hot dogs, luncheon meats (cold cuts), fermented and dry sausage and other deli-style meat or poultry products unless reheated until steaming hot;
  - Refrigerated pâté or meat spreads;
  - Unpasteurized milk or foods containing unpasteurized milk;
  - Soft cheeses 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 eggs or foods containing raw or lightly cooked eggs including certain salad dressings, cookie and cake batters, sauces, and beverages such as unpasteurized eggnog;
  - Raw sprouts (alfalfa, clover, and radish); or
  - Unpasteurized fruit or vegetable juices.

Priority 4
07/09

Assumed Risk for Women and Children over 2 Years

- A pregnant woman who meets the income and residential eligibility requirements may be presumed to be at nutrition risk based on failure to meet Dietary Guidelines after the Kansas WIC Program Prenatal Diet Questionnaire has been assessed and no other risk factors are identified. For this criterion, failure to meet Dietary Guidelines is defined as consuming fewer than the recommended number of servings from one or more of the basic food groups (grains, fruits, vegetables, milk products, and meat or beans) based on an individual’s estimated energy needs.

Priority 4
06/12

✔ Eating Disorders

- Presence of eating disorder(s) diagnosed by a physician as self-reported by client; or as reported or documented by a physician, or someone working under physician’s orders or evidence of such disorders documented by the CPA. Eating disorders (anorexia nervosa and bulimia) are characterized by a disturbed sense of body image and morbid fear of becoming fat. Symptoms are manifested by abnormal eating patterns including, but not limited to:
  - self-induced vomiting;
  - purgative abuse;
  - alternating periods of starvation;
- use of drugs such as appetite suppressants, thyroid preparations or diuretics; or
- self-induced marked weight loss.

Priority 1
04/01

Oral Health Conditions
- Diagnosis of oral health conditions a physician, dentist, or someone working under a physician’s orders as self-reported by client; or as reported or documented by a physician or dentist, or someone working under physician’s orders. Includes, but is not limited to:
  - Dental caries/cavities/tooth decay;
  - Periodontal disease (either stage - gingivitis or periodontitis); and
  - Tooth loss, ineffectively replaced teeth or oral infections which impair the ability to ingest food in adequate quantity or quality.

Priority 1
11/13

Disabilities Interfering with the Ability to Eat
- Developmental, sensory or motor disabilities that restrict the ability to consume chew or swallow food or require tube feeding to meet nutritional needs. Disabilities include but are not limited to:
  - minimal brain function;
  - feeding problems due to a developmental disability such as pervasive development disorder (PDD) which includes autism;
  - birth injury;
  - head trauma;
  - brain damage; or
  - other disabilities.

Priority 1
04/01

Tobacco Smoke Exposure in the Home
- Living with someone who smokes inside the home. KWIC will assign if Does anyone else smoke in the home? is “Yes…” on most recent Health Interview/ATOD record.

Priority 1
06/07

Nutrient Deficiency or Disease
- Any currently treated or untreated nutrient deficiency or disease as diagnosed by a physician as self-reported by client; or as reported or documented by a physician, or someone working under physician's orders. Diseases include, but are not limited to:
- Protein Energy Malnutrition;
- Scurvy;
- Rickets;
- Beriberi;
- Hypocalcemia;
- Osteomalacia;
- Vitamin K Deficiency;
- Pellagra;
- Xerophthalmia, and
- Iron Deficiency.

Priority 1 06/18

**High Parity and Young Age**
- Women under age 20 at date of conception for the current pregnancy, who have had 3 or more previous pregnancies of at least 20 weeks duration, regardless of birth outcome.

Priority 1 04/01

**Inadequate Prenatal Care**
- First prenatal visit in the third trimester (7-9 months) or:

<table>
<thead>
<tr>
<th>Weeks Gestation</th>
<th>Number of prenatal visits</th>
</tr>
</thead>
<tbody>
<tr>
<td>14 - 21</td>
<td>0 or unknown</td>
</tr>
<tr>
<td>22 - 29</td>
<td>1 or less</td>
</tr>
<tr>
<td>30 - 31</td>
<td>2 or less</td>
</tr>
<tr>
<td>32 - 33</td>
<td>3 or less</td>
</tr>
<tr>
<td>34 or more</td>
<td>4 or less</td>
</tr>
</tbody>
</table>

KWIC will auto-assign using the most recent Health Interview for this pregnancy:
- If *Month Prenatal Care Began* on the most recent Health Interview record is greater than seven (7), or
- If weeks gestation is ≥14 weeks and *Month Prenatal Care Began* is No Medical Care, or
- If gestation weeks at *First Prenatal Visit Date* is ≥14.

*Staff must also assess using the table and manually assign if appropriate

Priority 1 04/01

**Pregnant Woman Currently Breastfeeding**
- Breastfeeding woman now pregnant.

Priority 1 04/01
✔ Hyperemesis Gravidarum
   • Presence of Hyperemesis Gravidarum diagnosed by a physician as self-reported by the client, or as reported or documented by a physician, or someone working under physician’s orders. Hyperemesis Gravidarum is defined as severe and persistent nausea and vomiting during pregnancy which may cause more than 5% weight loss and fluid and electrolyte imbalances. This nutrition risk is based on a chronic condition, not single episodes. Hyperemesis Gravidarum is a clinical diagnosis, made after other causes of nausea and vomiting have been excluded.

History of Large for Gestational Age Infant Birth
   • Any history of giving birth to an infant weighing ≥ 9 lbs. (4000 grams). Must be diagnosed by a physician as self-reported by client; or as reported or documented by a physician, or someone working under physician’s orders. KWIC will auto-assign if the birth weight of any infants or children is greater than or equal to 9 lb, or if History of a Large for Gestational Age Infant Birth or Large for Gestational Age infant Born at Last Delivery was recorded during any previous certification.
   *Staff must assess and manually assign if the woman was not previously enrolled in the Kansas WIC Program or previous data is not recorded in KWIC.

History of Preterm Delivery
   • Any history of delivery of an infant born ≤ 36 6/7 weeks gestation. KWIC will auto-calculate if the woman has ever had History of Preterm Delivery or Preterm Delivery at Last Delivery risk factor assigned for any previous certification.
   *Staff must assess and manually assign if the woman was not previously enrolled in the Kansas WIC Program or previous data is not recorded in KWIC.

History of Early Term Delivery
   • Any history of delivery of an infant born ≥ 37 0/7 and ≤38 6/7 weeks gestation. KWIC will auto-calculate if the woman has ever had History of Early Term Delivery or Early Term Delivery at Last Delivery risk factor assigned for any previous certification.
   *Staff must assess and manually assign if the woman was not previously enrolled in the Kansas WIC Program or previous data is not recorded in KWIC.
*History of Low Birth Weight*
- Any history of giving birth to an infant born weighing \( \leq 5 \text{ lb 8 oz} \) (\( \leq 2500 \text{ grams} \)). KWIC will auto-assign if History of Low Birth Weight or Low Birthweight Infant Born at Last Delivery is recorded for any previous certification.
  *Staff must assess and manually assign if the woman was not previously enrolled in the Kansas WIC Program or the risk factor was not previously assigned.*

**Priority 1**  
04/01

*History of Birth with Nutrition Related Birth Defect*
- Any history of giving birth to an infant who has a congenital or birth defect linked to inappropriate nutritional intake, e.g., inadequate zinc, folic acid, excess vitamin A. The infant’s condition must be diagnosed by a physician as self-reported by client; or as reported or documented by a physician, or someone working under physician’s orders.

**Priority 1**  
04/01

*History of Fetal or Neonatal Loss*
- Any history of fetal or neonatal death or 2 or more spontaneous abortions. Must be diagnosed by a physician as self-reported by client; or as reported or documented by a physician, or someone working under physician’s orders.
  - Fetal death is the spontaneous termination of a gestation at \( \geq 20 \) weeks.
  - Neonatal death is the death of an infant within 0-28 days of life.
  - A spontaneous abortion (SAB) is the spontaneous termination of a gestation at \(< 20 \) weeks gestation or \(< 500 \) grams.

KWIC will auto-assign if the History of Fetal or Neonatal Loss Risk Factor assigned for any previous certification.
  *Staff must assess and manually assign if the woman was not previously enrolled in the Kansas WIC Program or previous data is not recorded in KWIC.*

**Priority 1**  
04/01

*Cancer*
- Presence of cancer as diagnosed by a physician as self-reported by client; or as reported or documented by a physician, or someone working under physician’s orders. The current condition, or the treatment for the condition, must be severe enough to affect nutritional status.

**Priority 1**  
04/01
**Celiac Disease**
- Presence of Celiac Disease (CD) diagnosed by a physician as self-reported by client; or as reported or documented by a physician or someone working under physician's orders. CD is an autoimmune disease precipitated by the ingestion of gluten (a protein in wheat, rye, and barley) that results in damage to the small intestine and malabsorption of the nutrients from food. Celiac Disease is also known as:
  - Celiac Sprue;
  - Gluten Enteropathy; or
  - Non-tropical Sprue.

**Central Nervous System Disorders**
- Presence of central nervous system disorders diagnosed by a physician as self-reported by client; or as reported or documented by a physician, or someone working under physician's orders. Central Nervous System Disorders are conditions which affect energy requirements, ability to feed self, or alter nutritional status metabolically, mechanically, or both. These include, but are not limited to:
  - Epilepsy;
  - Cerebral Palsy (CP);
  - Neural tube defects (NTDs), such as spina bifida;
  - Parkinson’s Disease; or
  - Multiple Sclerosis.

**Depression**
- Presence of clinical depression, including postpartum depression as diagnosed by a physician or clinical psychologist as self-reported by client; or as reported or documented by a physician or clinical psychologist, or someone working under physician’s orders.

**Food Allergies**
- Presence of food allergies diagnosed by a physician as self-reported by the caregiver; or as reported or documented by a physician, or someone working under physician’s orders. Food allergies are adverse health effects arising from a specific immune response that occurs reproducibly on exposure to a given food.
Gastrointestinal Disorders

- Presence of gastrointestinal disorders diagnosed by a physician, as self-reported by client; or as reported or documented by a physician, or someone working under physician’s orders. Gastrointestinal disorders are diseases and/or conditions that interfere with the intake, digestion, and/or absorption of nutrients. The diseases and/or conditions include, but are not limited to:
  - Gastroesophageal reflux disease (GERD);
  - Peptic ulcer;
  - Post-bariatric surgery;
  - Short bowel syndrome;
  - Inflammatory bowel disease, including ulcerative colitis or Crohn’s disease;
  - Liver disease;
  - Pancreatitis; or
  - Biliary tract diseases.

Genetic and Congenital Disorders

- Presence of a hereditary or congenital condition at birth that causes physical or metabolic abnormality, such as genetic and congenital disorders as diagnosed by a physician as self-reported by client; or as reported or documented by a physician, or someone working under physician’s orders. The current condition must alter nutrition status metabolically, mechanically, or both. May include, but is not limited to:
  - Cleft lip or palate;
  - Down’s syndrome;
  - Thalassemia major;
  - Sickle cell anemia (not sickle cell trait); and
  - Muscular dystrophy.

Hypoglycemia

- Presence of hypoglycemia diagnosed by a physician, as self-reported by client; or as reported or documented by a physician, or someone working under a physician’s orders.

Inborn Errors of Metabolism

- Presence of inherited metabolic disorder caused by a defect in the enzymes or their co-factors that metabolize protein, carbohydrate, or fat, diagnosed by a physician as self-reported by client; or as reported or documented by a physician, or someone working under physician’s orders. Inborn errors of metabolism (IEM)
generally refer to gene mutations or gene deletions that alter metabolism in the body, including but not limited to:

- **Amino Acid Disorders** - Amino Acid Metabolism Disorders are characterized by the inability to metabolize a certain essential amino acid. The build-up of the amino acid that is not metabolized can be toxic. Treatment of amino acid disorders involves restricting one or more essential amino acids to the minimum required for growth and development and supplying the missing product due to the blocked reaction.
  - Phenylketonuria (includes clinically significant hyperphenylalaninemia variants);
  - Maple syrup urine disease;
  - Homocystinuria;
  - Tyrosinemia;

- **Carbohydrate Disorders** - This group of disorders includes an enzyme deficiency or its cofactor that affects the catabolism or anabolism of carbohydrate. Carbohydrate disorders are complex and affect neurological, physical, and nutritional status.
  - Galactosemia
  - Glycogen storage disease type I
  - Glycogen storage disease type II (see also Pompe disease)
  - Glycogen storage disease type III
  - Glycogen storage disease type IV (Andersen Disease)
  - Glycogen storage disease type V
  - Glycogen storage disease type VI
  - Hereditary Fructose Intolerance (Fructose 1-phosphate aldolase deficiency, Fructose 1, 6, biphosphatase deficiency, fructose kinase deficiency)

- **Fatty Acid Oxidation Disorders** - Fatty acid oxidation defects include any enzyme defect in the process of mitochondrial fatty acid oxidation (FAO) system. The biochemical characteristic of all FAO defects is abnormally low ketone production as a result of the increased energy demands. This results in fasting hypoglycemia with severe acidosis secondary to the abnormal accumulation of intermediate metabolites of FAO, which can result in death.
  - Medium-chain acyl-CoA dehydrogenase deficiency
  - Long-chain 3-hydroxyacyl-CoA dehydrogenase deficiency
  - Trifunctional protein deficiency type 1 (LCHAD deficiency)
  - Trifunctional protein deficiency type 2 (mitochondrial trifunctional protein deficiency)
  - Carnitine uptake defect (primary carnitine deficiency)
  - Very long-chain acyl-CoA dehydrogenase deficiency

- **Organic Acid Metabolism Disorders** - Organic Acid Disorders are characterized by the excretion of non-amino organic acids in the urine. Most of the disorders are caused by a deficient enzyme involving the catabolism of specific amino acid(s). As a result, the non-metabolized substance accumulates due to the blockage of the specific metabolic pathway, which is toxic to certain organs and may also cause damage to the brain.
  - Isovaleric acidemia
Lysosomal Storage Diseases - Lysosomal storage diseases are a group of related conditions characterized by increased storage of undigested large molecules in lysosomes. Lysosomes are cellular organelles responsible for intracellular degradation and recycling of macromolecules. Due to a defect in a specific lysosomal enzyme, the macromolecule that normally would be metabolized is not broken down; instead, it accumulates in the lysosomes. This leads to tissue damage, organ failure and premature death. Common clinical features include bone abnormalities, organomegaly, developmental impairment and central, peripheral nervous system disorders.

- **Fabry disease** (α-galactosidase A deficiency)
- **Gauchers disease** (glucocerebrosidase deficiency)
- **Pompe disease** (glycogen storage disease Type II, or acid α-glucosidase deficiency)

Mitochondrial Disorders - Mitochondrial Disorders are caused by the dysfunction of the mitochondrial respiratory chain, or electron transport chain (ETC). Mitochondria play an essential role in energy production. The ETC dysfunction increases free radical production, which causes mitochondrial cellular damage, cell death and tissue necrosis and further worsens ETC dysfunction and thus forms a vicious cycle. The disorders can affect almost all organ systems. However, the organs and cells that have the highest energy demand, such as the brain and muscles (skeletal and cardiac) are most affected. The clinical features vary greatly among this group of disorders, but most have multiple organ dysfunctions with severe neuropathy and myopathy.

- **Leber hereditary optic neuropathy**
- **Mitochondrial encephalomyopathy, lactic acidosis, and stroke-like episodes (MELAS)**
- **Mitochondrial neurogastrointestinal encephalopathy disease** (MNGIE)
- **Myoclonic epilepsy with ragged-red fibers** (MERRF)
- **Neuropathy, ataxia, and retinitis pigmentosa** (NARP)
- **Pyruvate carboxylase deficiency**

Peroxisomal Disorders - There are two types of peroxisomal disorders: single peroxisomal enzyme deficiencies and peroxisomal biogenesis disorders. These disorders cause severe seizures and psychomotor retardation. Peroxisomes are small organelles found in cytoplasm of all cells. They carry out oxidative reactions which generate hydrogen peroxides. They also contain catalase (peroxidase), which is important in detoxifying ethanol, formic acid and other toxins. Single peroxisomal enzyme deficiencies are diseases with dysfunction of
a specific enzyme, such as acyl coenzyme A oxidase deficiency. Peroxisomal biogenesis disorders are caused by multiple peroxisome enzymes such as Zellweger syndrome and neonatal adrenoleukodystrophy.

- **Zellweger Syndrome Spectrum**
- **Adrenoleukodystrophy (x-ALD)**

**Urea Cycle Disorders** - Urea Cycle Disorders occur when any defect or total absence of any of the enzymes or the cofactors used in the urea cycle results in the accumulation of ammonia in the blood. The urea cycle converts waste nitrogen into urea and excretes it from the kidneys. Since there are no alternate pathways to clear the ammonia, dysfunction of the urea cycle results in neurologic damages.

- **Citrullinemia**
- **Argininosuccinic aciduria**
- **Carbamoyl phosphate synthetase I deficiency**

**Infectious Diseases - Acute**

- A disease which is characterized by a single or repeated episode of relatively rapid onset and short duration. Infectious diseases come from bacteria, viruses, parasites, or fungi and spread directly or indirectly from person to person. Infectious diseases may also be zoonotic, which are transmitted from animals to humans, or vector-borne, which are transmitted from mosquitoes, ticks, and fleas to humans. These diseases and/or conditions include, but are not limited to the following table. An extensive listing of infectious diseases can be found at [https://medlineplus.gov/infections.html](https://medlineplus.gov/infections.html).

<table>
<thead>
<tr>
<th>Common Acute Infectious Diseases</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hepatitis A</td>
</tr>
<tr>
<td>Hepatitis E</td>
</tr>
<tr>
<td>Meningitis (Bacterial/Viral)</td>
</tr>
<tr>
<td>Parasitic Infections</td>
</tr>
</tbody>
</table>

The infectious disease must be present within the past six months, and diagnosed by a physician as self-reported by the client/caregiver; or as reported or documented by a physician or someone working under a physician’s orders.

**Infectious Diseases - Chronic**

- Conditions likely lasting a lifetime and require long-term management of symptoms. Infectious diseases come from bacteria, viruses, parasites, or fungi and spread directly or indirectly from person to person. Infectious diseases may also
be zoonotic, which are transmitted from animals to humans, or vector-borne, which are transmitted from mosquitoes, ticks, and fleas to humans. These
diseases and/or conditions include, but are not limited to the following table. An
extensive listing of infectious diseases can be found at

<table>
<thead>
<tr>
<th>Common Chronic Infectious Diseases</th>
</tr>
</thead>
<tbody>
<tr>
<td>HIV-Human Immunodeficiency Virus</td>
</tr>
<tr>
<td>AIDS-Acquired Immunodeficiency Syndrome</td>
</tr>
<tr>
<td></td>
</tr>
</tbody>
</table>

Presence of condition diagnosed by a physician as self-reported by the
client/caregiver; or as reported or documented by a physician or someone working
under a physician’s orders.

Priority 1  
06/2016

Lactose Intolerance

- Presence of lactose intolerance diagnosed by a physician as self-reported by
  client; or as reported or documented by a physician, or someone working under
  physician’s orders. Lactose intolerance is the syndrome of one or more of the
  following: diarrhea, abdominal pain, flatulence, and/or bloating, that occurs after
  lactose ingestion.

Priority 1  
06/12

Other Medical Conditions

- Presence of medical condition(s) with nutritional implications that are not
  included in any of the other medical conditions diagnosed by a physician as
  self-reported by client; or as reported or documented by a physician, or someone working under
  physician’s orders. The current condition, or
treatment for the condition, must be severe enough to affect nutritional
status. Includes, but is not limited to:
  - Juvenile rheumatoid arthritis (JRA);
  - Lupus erythematosus;
  - Cardiorespiratory diseases;
  - Heart disease;
  - Cystic fibrosis; or
  - Persistent asthma (moderate or severe) requiring daily medication.

Priority 1  
04/01
✓ Recent Major Surgery, Trauma, Burns
  • Major surgery, trauma or burns severe enough to compromise nutritional status. Any occurrence:
    • within the past two (≤2) months may be self-reported;
    • more than two (>2) months previous must have the continued need for nutritional support diagnosed by a physician or a health care provider working under the orders of a physician.

Priority 1
04/01

✓ Renal Disease
  • Presence of renal disease diagnosed by a physician as self-reported by client; or as reported or documented by a physician, or someone working under physician’s orders. Any renal disease including pyelonephritis and persistent proteinuria, but excluding urinary tract infections (UTI) involving the bladder.

Priority 1
04/01

Thyroid Disorders
  • Presence of a thyroid disorder diagnosed by a physician as self-reported by client; or as reported or documented by a physician, or someone working under physician’s orders. The medical conditions include, but are not limited to, the following:
    • Hyperthyroidism - Excessive thyroid hormone production (most commonly known as Graves’ disease and toxic multinodular goiter).
    • Hypothyroidism - Low secretion levels of thyroid hormone (can be overt or mild/subclinical). Most commonly seen as chronic autoimmune thyroiditis (Hashimoto’s thyroiditis or autoimmune thyroid disease). It can also be caused by severe iodine deficiency.

Priority 1
04/01

✓ Drug Nutrient Interactions
  • Use of prescription or over-the-counter drugs or medications that have been shown to interfere with nutrient intake, absorption, distribution, metabolism, or excretion, to an extent that nutritional status is compromised.

Priority 1
05/11

Elevated Blood Lead Levels
  • Blood lead level of ≥ 5 μg/deciliter within the past 12 months

Priority 1
05/15
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.

Priority 7
4/01

 '>' Underweight
- Prepregnancy Body Mass Index (BMI) <18.5.

Priority 1
07/09

 '>' Overweight
- Prepregnancy Body Mass Index (BMI) ≥25.1

Priority 1
07/09

 '>' Low Maternal Weight Gain
- Low weight gain at any point in pregnancy, such that either A or B apply. Note that, the weight gain recommendations in the tables are for singleton pregnancies, but will be used for multi-fetal pregnancies when determining WIC eligibility.
  - A. A low rate of gain, such that in the 2nd and 3rd trimesters,

<table>
<thead>
<tr>
<th>Prepregnancy Weight Classification 1</th>
<th>BMI</th>
<th>Total Weight Gain (lbs.)/Week</th>
</tr>
</thead>
<tbody>
<tr>
<td>Underweight</td>
<td>&lt; 18.5</td>
<td>&lt; 1</td>
</tr>
<tr>
<td>Normal weight</td>
<td>18.5 – 24.9</td>
<td>&lt; 0.8</td>
</tr>
<tr>
<td>Overweight</td>
<td>25 – 29.9</td>
<td>&lt; 0.5</td>
</tr>
<tr>
<td>Obese</td>
<td>≥ 30.0</td>
<td>&lt; 0.4</td>
</tr>
</tbody>
</table>

- B. Low weight gain at any point in pregnancy, such that using a National Academies of Sciences, Medicine, and Engineering (NASEM-formerly known as the Institute of Medicine)-based weight gain grid, a pregnant woman’s weight plots at any point beneath the bottom line of the appropriate singleton weight gain range for her respective prepregnancy weight category. Although the risk factor is assigned using the singleton weight gain range, information on recommended weight gain ranges for multifetal pregnancies is provided for counseling purposes.

1 For Risk Factors related to women’s weight status: Until research supports the use of different BMI cut-offs to determine weight status categories for adolescent pregnancies, the same BMI cut-offs will be used for all women, regardless of age, when determining WIC eligibility.
Prepregnancy Weight Classification | Total Weight Gain Range (lbs)  
---|---
**Singleton** | **Twins**
Underweight | BMI <18.5 | 28 to 40 | Not Available
Normal weight | BMI 18.5 to 24.9 | 25 to 35 | 37 to 54
Overweight | BMI 25.0 to 29.9 | 15 to 25 | 31 to 50
Obese | BMI ≥ 30.0 | 11 to 20 | 25 to 42

KWIC will auto-assign for either A or B.

**High Maternal Weight Gain**
- High weight gain at any point in pregnancy, such that using an Institute of Medicine (IOM)-based weight gain grid, a pregnant woman’s weight plots at any point above the top line of the appropriate singleton weight gain range for her respective prepregnancy weight category. The risk factor is assigned using the singleton weight gain range, information on recommended weight gain ranges for multifetal pregnancies is provided for counseling purposes.

**Multifetal Gestation**
- More than one (>1) fetus in the current pregnancy.

---

2 For Risk Factors related to women’s weight status: Until research supports the use of different BMI cut-offs to determine weight status categories for adolescent pregnancies, the same BMI cut-offs will be used for all women, regardless of age, when determining WIC eligibility.

3 For triplets the overall gain should be around 50 pounds with a steady rate of gain of approximately 1.5 pounds per week throughout the pregnancy.

4 There is insufficient information to develop guidelines for underweight women with multiple fetuses. A gain of 1.5 pounds per week during the second and third trimesters has been associated with a reduced risk of preterm and low-birth weight delivery in twin pregnancy.
Low Hemoglobin / Hematocrit, 1\textsuperscript{st} Trimester
- Hemoglobin less than (<) 11.0 g/dl
- Hematocrit concentration less than (<) 33%

Low Hemoglobin / Hematocrit, 2\textsuperscript{nd} Trimester
- Hemoglobin less than (<) 10.5 g/dl
- Hematocrit concentration less than (<) 32%

Low Hemoglobin / Hematocrit, 3\textsuperscript{rd} Trimester
- Hemoglobin less than (<) 11.0 g/dl
- Hematocrit concentration less than (<) 33%

Hypertension and Prehypertension
- Presence of hypertension or prehypertension diagnosed by a physician as self-reported by client; or as reported or documented by a physician, or someone working under physician's orders.
  - Hypertension is persistently high arterial blood pressure with systolic blood pressure above 140 mm Hg or diastolic blood pressure above 90 mm Hg (140/90).
  - Prehypertension is blood pressure readings between 130/80 to 139/89 mm Hg.

Pregnancy Induced Hypertension
- Presence of pregnancy induced hypertension diagnosed by a physician as self-reported by client; or as reported or documented by a physician, or someone working under physician's orders. The term “pregnancy-induced hypertension” includes gestational hypertension, preeclampsia and eclampsia.
  - Gestational Hypertension - Blood pressure elevation detected for the first time after midpregnancy without proteinuria. It presents minimal risks to mother and baby, when it does not progress to preeclampsia.
  - Preeclampsia - A pregnancy-specific syndrome observed after the 20\textsuperscript{th} week of pregnancy with elevated blood pressure accompanied by significant proteinuria.
  - Eclampsia - The occurrence of seizures, in a woman with preeclampsia, that cannot be attributed to other causes.
History of Preeclampsia
- Any history of preeclampsia diagnosed by a physician as self-reported by client; or as reported or documented by a physician, or someone working under a physician's orders. Preeclampsia is defined as pregnancy-induced hypertension (>140 mm Hg systolic or 90 mm Hg diastolic) with proteinuria.

Priority 1
07/09

Diabetes Mellitus
- Presence of diabetes mellitus diagnosed by a physician, as self-reported by client; or as reported or documented by a physician, or someone working under a physician’s orders.
- Diabetes mellitus consists of a group of metabolic diseases characterized by inappropriate hyperglycemia resulting from defects in insulin secretion, insulin action or both.

Priority 1
07/09

Gestational Diabetes
- Presence of gestational diabetes diagnosed by a physician as self-reported by client; or as reported or documented by a physician, or someone working under physician’s orders.
- Gestational diabetes mellitus (GDM) is defined as any degree of glucose/carbohydrate intolerance with onset or first recognition during pregnancy.

Priority 1
07/09

History of Gestational Diabetes
- Any history of gestational diabetes. The condition must be diagnosed by a physician as self-reported by client; or as reported or documented by a physician, or someone working under physician’s orders.

Priority 1
07/09

Pregnancy at a Young Age
- Conception of current pregnancy at 17 years of age or younger.

Priority 1
04/01

Short Interpregnancy Interval
- Interpregnancy interval of <18 months from the date of a live birth to the conception of the subsequent pregnancy.

Priority 1
05/15
**Maternal Smoking**
- Any daily smoking of tobacco products, i.e., cigarettes, pipes, or cigars.

**Alcohol and Substance Use**
- Any alcohol use;
- Any illegal drug use and/or abuse of prescription medications;
- Any marijuana use in any form.

For Pregnant women, KWIC will auto-assign if any of the following are true for the current assessment:
- Any alcohol use in Now row on ATOD screen
- Illegal Drug Use is selected on ATOD screen
- Misuse of prescription medications is selected on ATOD screen
- Any marijuana use in any form is selected on ATOD screen

**Woman or Primary Caregiver with Limited Ability**
- A woman or infant/child whose primary caregiver is assessed to have a limited ability to make appropriate feeding decisions and/or prepare food. Examples include, but are not limited to, a woman or an infant/child of primary caregiver with the following:
  - Documentation or self-report of misuse of alcohol, use of illegal substances, use of marijuana, or misuse of prescription medications.
  - Mental illness, including clinical depression diagnosed, documented, or reported by a physician or psychologist or someone working under a physician’s orders, or as self-reported by applicant/client/caregiver.
  - Intellectual disability diagnosed, documented, or reported by a physician or psychologist or someone working under a physician’s orders, or as self-reported by applicant/client/caregiver.
  - Physical disability to a degree which impairs ability to feed infant/child or limits food preparation abilities.
  - ≤ 17 years of age.

For Pregnant women, KWIC will auto-assign if any of the following are true for the current assessment:
- Has NRF Alcohol and Substance Use assigned
  - Any alcohol use in Now row on ATOD screen.
  - Illegal Drug Use is selected on ATOD screen
  - Misuse of prescription medications is selected on ATOD screen
  - Any marijuana use in any form is selected on ATOD screen
- Has NRF Depression assigned
- Is ≤ 17 years of age.

- Staff must also assess for other possible reasons and manually assign if appropriate.

Priority 4  
6/18

**Migrancy**

- A woman who is a member of a family which contain at least one individual whose principal employment is in agriculture on a seasonal basis, who has been so employed within the last 24 months, and who establishes, for the purposes of such employment, a temporary abode.

Priority 7  
04/01

**Homelessness**

- A woman who lacks a fixed and regular nighttime residence; or whose primary nighttime residence is:
  - a supervised publicly or privately operated shelter (including a welfare hotel, a congregate shelter, or a shelter for victims of domestic violence) designed to provide temporary living accommodations;
  - an institution that provides a temporary residence for individuals intended to be institutionalized;
  - a temporary accommodation of not more than 365 days in the residence of another individual; or
  - a public or private place not designed for, or ordinarily used as, a regular sleeping accommodation for human beings.

Priority 7  
04/01

**Transfer of Certification**

Person with current valid Verification of Certification (VOC) document from another State 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 risk is not used when active clients transfer between Kansas Local Agencies because KWIC transfers all existing risk factors with the client.

- KWIC will auto-assign this risk factor when a staff member completes the Transfer from Out of State process.

Priority 1  
04/01
Presumptive Eligibility for Pregnant Women

- A pregnant woman who meets WIC income eligibility standards but has not yet been evaluated for nutrition risk, for a period of up to 60 days.
- In rare cases, local agencies may not have the essential staff onsite to perform the necessary bloodwork assessment for pregnant women.
- Ideally, the full nutrition risk assessment is completed at certification or at the earliest possible date thereafter.
- The nutrition risk evaluation must be completed not later than 60 days from the date the pregnant woman is presumed eligible for participation.
Table 1 - Risk Factors for Pregnant Women with Priority & USDA Risk Code

For a listing of the USDA risk codes and priorities for all categories, see PPM CRT 07.00.00 - Nutrition Eligibility.

<table>
<thead>
<tr>
<th>Risk Factor</th>
<th>Priority</th>
<th>USDA Risk Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alcohol and Substance Use</td>
<td>1</td>
<td>372</td>
</tr>
<tr>
<td>Assumed Risk for Women &amp; Children over 2 yrs</td>
<td>4</td>
<td>401</td>
</tr>
<tr>
<td>Cancer</td>
<td>1</td>
<td>347</td>
</tr>
<tr>
<td>Celiac Disease</td>
<td>1</td>
<td>354</td>
</tr>
<tr>
<td>Central Nervous System Disorders</td>
<td>1</td>
<td>348</td>
</tr>
<tr>
<td>Consuming Foods that Could Be Contaminated</td>
<td>4</td>
<td>427.5</td>
</tr>
<tr>
<td>Depression</td>
<td>1</td>
<td>361</td>
</tr>
<tr>
<td>Diabetes Mellitus</td>
<td>1</td>
<td>343</td>
</tr>
<tr>
<td>Diet Very Low in Calories and/or Essential Nutrients</td>
<td>4</td>
<td>427.2</td>
</tr>
<tr>
<td>Disabilities Interfering with the Ability to Eat</td>
<td>1</td>
<td>362</td>
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<tr>
<td>Drug Nutrient Interactions</td>
<td>1</td>
<td>357</td>
</tr>
<tr>
<td>Eating Disorders</td>
<td>1</td>
<td>358</td>
</tr>
<tr>
<td>Elevated Blood Lead Levels</td>
<td>1</td>
<td>211</td>
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<tr>
<td>Food Allergies</td>
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<td>353</td>
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<tr>
<td>Foster Care</td>
<td>7</td>
<td>903</td>
</tr>
<tr>
<td>Gastrointestinal Disorders</td>
<td>1</td>
<td>342</td>
</tr>
<tr>
<td>Genetic and Congenital Disorders</td>
<td>1</td>
<td>349</td>
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<tr>
<td>Gestational Diabetes</td>
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<td>302</td>
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<tr>
<td>High Maternal Weight Gain</td>
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<tr>
<td>High Parity and Young Age</td>
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<tr>
<td>History of a Large for Gestational Age Infant Birth</td>
<td>1</td>
<td>337</td>
</tr>
<tr>
<td>History of Birth with Nutrition Related Birth Defect</td>
<td>1</td>
<td>339</td>
</tr>
<tr>
<td>History of Early Term Delivery</td>
<td>1</td>
<td>311</td>
</tr>
<tr>
<td>History of Fetal or Neonatal Loss</td>
<td>1</td>
<td>321</td>
</tr>
<tr>
<td>History of Gestational Diabetes</td>
<td>1</td>
<td>303</td>
</tr>
<tr>
<td>Risk Factor</td>
<td>Priority</td>
<td>USDA Risk Code</td>
</tr>
<tr>
<td>-------------------------------------------------</td>
<td>----------</td>
<td>----------------</td>
</tr>
<tr>
<td>History of Low Birth Weight</td>
<td>1</td>
<td>312</td>
</tr>
<tr>
<td>History of Preeclampsia</td>
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<td>304</td>
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<tr>
<td>History of Preterm Delivery</td>
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<td>311</td>
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<tr>
<td>Homelessness</td>
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<td>801</td>
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<tr>
<td>Hyperemesis Gravidarum</td>
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<td>301</td>
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<tr>
<td>Hypertension and Prehypertension</td>
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<tr>
<td>Hypoglycemia</td>
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<td>356</td>
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<tr>
<td>Inadequate Prenatal Care</td>
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<td>334</td>
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<tr>
<td>Inadequate Vitamin/Mineral Supplementation</td>
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<td>427.4</td>
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<tr>
<td>Inborn Errors of Metabolism</td>
<td>1</td>
<td>351</td>
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<tr>
<td>Infectious Diseases - Acute</td>
<td>1</td>
<td>352a</td>
</tr>
<tr>
<td>Infectious Diseases - Chronic</td>
<td>1</td>
<td>352b</td>
</tr>
<tr>
<td>Intake of Dietary Supplements with Harmful Effects</td>
<td>4</td>
<td>427.1</td>
</tr>
<tr>
<td>Lactose Intolerance</td>
<td>1</td>
<td>355</td>
</tr>
<tr>
<td>Low Hemoglobin/Hematocrit, 1st Trimester</td>
<td>1</td>
<td>201</td>
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<tr>
<td>Low Hemoglobin/Hematocrit, 2nd Trimester</td>
<td>1</td>
<td>201</td>
</tr>
<tr>
<td>Low Hemoglobin/Hematocrit, 3rd Trimester</td>
<td>1</td>
<td>201</td>
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<tr>
<td>Low Maternal Weight Gain</td>
<td>1</td>
<td>131</td>
</tr>
<tr>
<td>Maternal Smoking</td>
<td>1</td>
<td>371</td>
</tr>
<tr>
<td>Migrancy</td>
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<td>802</td>
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<tr>
<td>Multifetal Gestation</td>
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<td>335</td>
</tr>
<tr>
<td>Nutrient Deficiency or Disease</td>
<td>1</td>
<td>341</td>
</tr>
<tr>
<td>Oral Health Conditions</td>
<td>1</td>
<td>381</td>
</tr>
<tr>
<td>Other Medical Conditions</td>
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<td>360</td>
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<tr>
<td>Overweight</td>
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<tr>
<td>Pica</td>
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<tr>
<td>Pregnancy at a Young Age</td>
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<td>331</td>
</tr>
<tr>
<td>Pregnancy Induced Hypertension</td>
<td>1</td>
<td>345</td>
</tr>
<tr>
<td>Pregnant Woman Currently Breastfeeding</td>
<td>1</td>
<td>338</td>
</tr>
<tr>
<td>Presumptive Eligibility for Pregnant Women</td>
<td>4</td>
<td>503</td>
</tr>
<tr>
<td>Risk Factor</td>
<td>Priority</td>
<td>USDA Risk Code</td>
</tr>
<tr>
<td>------------------------------------------------------</td>
<td>----------</td>
<td>----------------</td>
</tr>
<tr>
<td>Recent Major Surgery, Trauma, Burns</td>
<td>1</td>
<td>359</td>
</tr>
<tr>
<td>Renal Disease</td>
<td>1</td>
<td>346</td>
</tr>
<tr>
<td>Short Interpregnancy Interval</td>
<td>1</td>
<td>332</td>
</tr>
<tr>
<td>Thyroid Disorders</td>
<td>1</td>
<td>344</td>
</tr>
<tr>
<td>Tobacco Smoke Exposure in the Home</td>
<td>1</td>
<td>904</td>
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<tr>
<td>Transfer of Certification</td>
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<tr>
<td>Underweight</td>
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<tr>
<td>Weight Loss During Pregnancy, 1st Trimester</td>
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<td>132</td>
</tr>
<tr>
<td>Weight Loss During Pregnancy, 2nd or 3rd Trimester</td>
<td>1</td>
<td>132</td>
</tr>
<tr>
<td>Woman or Primary Caregiver with Limited Ability</td>
<td>4</td>
<td>902</td>
</tr>
</tbody>
</table>
Table 2 - High-Risk Risk Factors for Pregnant Women

For information on providing nutrition education for high-risk clients, see PPM NED 02.03.00 - Nutrition Education Contact - Second, High Risk.

<table>
<thead>
<tr>
<th>Risk Factor</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alcohol and Substance Use</td>
</tr>
<tr>
<td>Cancer</td>
</tr>
<tr>
<td>Celiac Disease</td>
</tr>
<tr>
<td>Diabetes Mellitus</td>
</tr>
<tr>
<td>Drug Nutrient Interactions</td>
</tr>
<tr>
<td>Eating Disorders</td>
</tr>
<tr>
<td>Genetic and Congenital Disorders</td>
</tr>
<tr>
<td>Gestational Diabetes</td>
</tr>
<tr>
<td>History of Birth with Nutrition Related Birth Defect</td>
</tr>
<tr>
<td>History of Gestational Diabetes</td>
</tr>
<tr>
<td>Hyperemesis Gravidarum</td>
</tr>
<tr>
<td>Inborn Errors of Metabolism</td>
</tr>
<tr>
<td>Infectious Diseases - Acute</td>
</tr>
<tr>
<td>Infectious Diseases - Chronic</td>
</tr>
<tr>
<td>Low Hemoglobin / Hematocrit, 1st Trimester</td>
</tr>
<tr>
<td>Low Hemoglobin / Hematocrit, 2nd Trimester</td>
</tr>
<tr>
<td>Low Hemoglobin / Hematocrit, 3rd Trimester</td>
</tr>
<tr>
<td>Nutrient Deficiency or Disease</td>
</tr>
<tr>
<td>Recent Major Surgery, Trauma, Burns</td>
</tr>
<tr>
<td>Renal Disease</td>
</tr>
<tr>
<td>Underweight</td>
</tr>
<tr>
<td>Weight Loss During Pregnancy, 1st Trimester</td>
</tr>
<tr>
<td>Weight Loss During Pregnancy, 2nd or 3rd Trimester</td>
</tr>
</tbody>
</table>
Table 3 - Risk Factors requiring documentation of Physician Diagnosis

For the following risk factors the condition must be diagnosed by a physician as self-reported by client; or as reported or documented by a physician, or someone working under physician’s orders. Self-reporting of a diagnosis by a medical professional should not be confused with self diagnosis, where a person simply claims to have or to have had a medical condition without any reference to professional diagnosis. This should be documented by marking the [Risk Assigned Based on MD Diagnosis] check box on the Assign Risk Factors Window in KWIC.

<table>
<thead>
<tr>
<th>Risk Factor</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cancer</td>
</tr>
<tr>
<td>Celiac Disease</td>
</tr>
<tr>
<td>Central Nervous System Disorders</td>
</tr>
<tr>
<td>Depression</td>
</tr>
<tr>
<td>Diabetes Mellitus</td>
</tr>
<tr>
<td>Eating Disorders(^5)</td>
</tr>
<tr>
<td>Food Allergies</td>
</tr>
<tr>
<td>Gastrointestinal Disorders</td>
</tr>
<tr>
<td>Genetic and Congenital Disorders</td>
</tr>
<tr>
<td>Gestational Diabetes</td>
</tr>
<tr>
<td>History of a Large for Gestational Age Infant Birth</td>
</tr>
<tr>
<td>History of Birth with Nutrition Related Birth Defect(^6)</td>
</tr>
<tr>
<td>History of Fetal or Neonatal Loss</td>
</tr>
<tr>
<td>History of Gestational Diabetes</td>
</tr>
<tr>
<td>History of Preeclampsia</td>
</tr>
<tr>
<td>Hyperemesis Gravidarum</td>
</tr>
<tr>
<td>Hypertension and Prehypertension</td>
</tr>
<tr>
<td>Hypoglycemia</td>
</tr>
<tr>
<td>Inborn Errors of Metabolism</td>
</tr>
<tr>
<td>Infectious Diseases - Acute</td>
</tr>
<tr>
<td>Infectious Diseases - Chronic</td>
</tr>
<tr>
<td>Lactose Intolerance</td>
</tr>
<tr>
<td>Nutrient Deficiency or Disease</td>
</tr>
<tr>
<td>Oral Health Conditions(^7)</td>
</tr>
<tr>
<td>Other Medical Conditions</td>
</tr>
</tbody>
</table>

\(^5\) Eating disorders can also be assigned based on adequate documentation by the CPA

\(^6\) The diagnosis must be specific to the infant’s condition

\(^7\) Oral Health Conditions can also be assigned based on diagnosis, documentation or report by a dentist
<table>
<thead>
<tr>
<th>Risk Factor</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pregnancy Induced Hypertension</td>
</tr>
<tr>
<td>Recent Major Surgery, Trauma, Burns(^8)</td>
</tr>
<tr>
<td>Renal Disease</td>
</tr>
<tr>
<td>Thyroid Disorders</td>
</tr>
<tr>
<td>Woman or Primary Caregiver with Limited Ability</td>
</tr>
</tbody>
</table>

\(^8\) Any occurrence more than two (>2) months previous must have the continued need for nutritional support diagnosed by a physician or a health care provider working under the orders of a physician.