

WIC PEDIATRIC REFERRAL

Health Care Provider:

Please provide the information requested below for your patient. This information will be used by our Program staff to assess your patient's health status and to provide nutritional counseling. An incomplete referral may delay Program benefits to your patient. A completed referral does not guarantee WIC Program benefits since Program eligibility requirements must be met. **PLEASE NOTE: WIC provides iron-fortified concentrated liquid and powdered formulas ONLY.**

| | | | |
|------------------------------|----------------------------------|------------|--|
| Patient's name (last, first) | WIC identification number | Birth date | Sex <input type="checkbox"/> Male <input type="checkbox"/> Female |
| Parent/guardian name | Address (street, city, ZIP code) | | Phone number |

| CURRENT | CURRENT (For patients 9 months or older) | BIRTH DATA (For patients under 12 months) | BLOOD LEAD TEST | | |
|---|--|---|-----------------|------|-------|
| Length/height _____ ins. _____ / _____ / _____ Measurement Date | Hemoglobin _____ gm/dl and/or Hematocrit _____ % _____ / _____ / _____ Blood Test Date | Birthweight _____ lbs. Birthlength _____ ins. <input type="checkbox"/> Small for gestational age <input type="checkbox"/> Preterm (less than 37 wks) | | Date | µg/dL |
| Weight _____ lbs. | | | 12-month result | | |
| | | | 24-month result | | |

IF FORMULA WILL BE NECESSARY AFTER AGE 1 YEAR, REASON AND TYPE OF FORMULA MUST BE INDICATED:

Reason: _____

Type: _____

Estimated time needed: _____

PLEASE INDICATE ANY MEDICAL CONDITIONS AFFECTING THIS PATIENT:

Food Allergies Congenital Anomalies Developmental Disabilities Severe Dental Problems Illness, Acute Illness, Chronic

Other (specify): _____

PLEASE DESCRIBE ANY OF THE CONDITIONS INDICATED ABOVE. INCLUDE DATES WHEN APPLICABLE: _____

PLEASE LIST ANY CURRENT MEDICATIONS/SUPPLEMENTS PRESCRIBED: _____

| | |
|-------------------|--|
| LOCAL WIC AGENCY: | Name of Physician/Health Care Provider/Group/Clinic |
| | Phone Number: |
| | IMPORTANT: Must Be Signed by Health Care Provider |