NEW YORK STATE DEPARTMENT OF HEALTH
DIVISION OF NUTRITION

For WIC Use:

Date Mailed/ Given	Date Rec'd
Appt Date	WIC ID #

WIC MEDICAL REFERRAL FORM FOR INFANTS and CHILDREN

Child's Last Name (Print):_____ Child's First Name: _____

Parent/Caretaker's Name:_____ Street: _____ Apt: _____

City:_____ Zip:_____ On WIC Before: Yes ☐ No ☐ Sex: M ☐ F ☐

Phone: ( ) _____ - _____ Child's DOB: _____/_____/_____ Language(s) Spoken: _____

I authorize _____(Health Care Provider) to release the information below to the WIC Program, and I authorize the WIC Program to release information about my infant/child to this health care provider for the purposes of coordinating his/her health care. If I need to transfer to another WIC Program, I authorize the release of this information to the transferring WIC Program. All information is considered confidential.

YOUR SIGNATURE: _____

Health Care Provider: Please complete this section.

BIRTH HISTORY: ☐ SGA (<10th Weight for Gestational Age)

Birth Weight _____lb _____oz ***OR*** _____kg

Birth Length _____in ***OR*** _____cm Weeks Gestation_____

WEIGHT and HEIGHT must be less than 60 days old on the date of the WIC appointment _____/_____/_____ **Date Taken:**

Current Weight _____lb _____oz ***OR*** _____kg _____/_____/_____

Current Height/Length _____in ***OR*** _____cm _____/_____/_____

Measurement Taken: ☐ Standing ☐ Recumbent (< 2 yrs)

HEMATOLOGY: **Date Taken:**

Hgb _____gm/dL ***OR*** Hct_____ _____% ____/____/____

Blood Lead _____ mcg/dL at one year of age ____/____/____

Blood Lead _____ mcg/dL at two years of age ____/____/____

Provide marker IMMUNIZATION dates or attach a copy of record.

	First	Second	Third	Fourth	Fifth
Hep B					
DTP/D Tap					
MMR					

SPECIFIC MEDICAL DIAGNOSIS OR NUTRITIONAL/HEALTH RISKS including ICD-9 code

Signature of Health Care Provider

Provider's Name (Please Print):

Title:

Medical Office/Clinic:

Street:

City: Zip:

Phone #: Fax #:

Date: _____/_____/_____

Send Completed Form To: