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/DTap					
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: