

**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: <input type="checkbox"/> 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: <input type="checkbox"/> Standing <input type="checkbox"/> Recumbent (< 2 yrs)
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HEMATOLOGY: Hgb _____ gm/dL OR Hct _____ % Date Taken: ____/____/____ 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. <table border="1"> <thead> <tr> <th></th> <th>First</th> <th>Second</th> <th>Third</th> <th>Fourth</th> <th>Fifth</th> </tr> </thead> <tbody> <tr> <td>Hep B</td> <td></td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td>DTP/DTap</td> <td></td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td>MMR</td> <td></td> <td></td> <td></td> <td></td> <td></td> </tr> </tbody> </table>		First	Second	Third	Fourth	Fifth	Hep B						DTP/DTap						MMR					
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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:
