

**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)	WEIGHT and HEIGHT must be less than 60 days old on the date of the WIC appointment ____/____/____
Birth Weight ____lb ____oz OR ____kg	Date Taken: Current Weight ____lb ____oz OR ____kg ____/____/____
Birth Length ____in OR ____cm Weeks Gestation _____	Current Height/Length ____in OR ____cm ____/____/____
	Measurement Taken: <input type="checkbox"/> Standing <input type="checkbox"/> Recumbent (< 2 yrs)

HEMATOLOGY:	Date Taken:	Provide marker IMMUNIZATION dates or attach a copy of record.				
Hgb _____ gm/dL OR Hct _____ %	____/____/____	First	Second	Third	Fourth	Fifth
Blood Lead _____ mcg/dL at one year of age	____/____/____	Hep B				
Blood Lead _____ mcg/dL at two years of age	____/____/____	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:

**NEW YORK STATE DEPARTMENT OF HEALTH
DIVISION OF NUTRITION**

**For WIC
Use:**

Date Mailed/ Given	Date Rec'd
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WIC MEDICAL REFERRAL FORM FOR WOMEN

Last Name (Print): _____ First Name: _____
 Street: _____ Apt: _____ City: _____ Zip: _____
 Phone: () _____ - _____ Date of Birth: ____/____/____ On WIC Before: Yes No
 Maiden Name: _____ 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 me to this health care provider for the purposes of coordinating my 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.

PRENATAL OR POSTPARTUM:

Gravida _____ Para _____ Multi Fetal _____
 Pregravid Weight _____ pounds Date: _____
 EDD ____/____/____
 Prenatal Care Began ____/____/____
 Fetal Weight <10th Percentile for Gestational Age

WEIGHT and HEIGHT must be less than 60 days old on the date of the WIC appointment: ____/____/____

Date Taken:
 Current Weight _____ pounds _____/____/____
 Current Height _____ inches _____/____/____

HEMATOLOGY:

Hgb _____ gm/dL **OR** Hct _____ % _____/____/____
 Date Taken: _____
 Blood Lead _____ mcg/dL _____/____/____
 (Optional)

- Bloodwork must be taken during current pregnancy.
- Bloodwork must be taken after delivery for Breastfeeding/ Postpartum Women.

BREASTFEEDING/POSTPARTUM: Most Recent Pregnancy

Date of Delivery/(Termination, if any) ____/____/____
 Total Weight Gained _____ pounds Weeks Gestation _____
 Current Infant's Birth Weight _____ lb _____ oz **OR** _____ kg

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:

**NEW YORK STATE DEPARTMENT OF HEALTH
DIVISION OF NUTRITION**

**MEDICAL DOCUMENTATION FOR WIC FORMULA AND APPROVED WIC FOODS FOR
INFANTS, CHILDREN AND WOMEN**

Patient's Name _____ Birth Date: (MM/DD/YY) _____
 Parent/Caretaker's First and Last Name _____

I authorize _____ (Health Care Provider) to release the information below to the WIC Program, and I authorize the WIC Program to release information about me to this health care provider for the purposes of coordinating my 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: _____

Prescription is subject to WIC approval and provision based on Program policy and procedure.

Qualifying medical condition(s) including ICD-9 code: Justifies the prescription of requested formula/medical food
 _____ ICD-9 Code _____

WIC formula/medical food requested: _____
 Prescribed amount per day: _____ oz/day Special Instructions/Comments: _____
 Length of use: _____ (Prescription renewal required periodically)

The patient will receive the supplemental foods, appropriate to their WIC participant category, listed below in addition to the WIC formula/medical food. Please indicate any supplemental foods or restrictions that would be contraindicated with the patient's medical diagnosis.

WIC Participant Category	WIC Supplemental Foods Available	Do Not Give	Restrictions/Comments
Infants (6-12 months)	Infant Cereal		
	Infant Food Vegetables/Fruits		
Children and Women	Milk		
	Cheese		
	Cereal		
	Juice		
	Eggs		
	Vegetables/Fruits		
	Whole Wheat Bread		
	Beans		
	Peanut Butter		
	Canned Fish *		

* "Fully Breastfeeding Women" is the only WIC participant category eligible to receive canned fish.

Signature of Health Care Provider	Provider's Name (Please Print):	
	Title:	
	Medical Office/Clinic:	
	Street:	
	City:	Zip:
	Phone #:	Fax #:
	Date: / /	