Louisiana WIC Program Medical Referral Form

Plese complete shaded areas. ***Guardian: Please bring a copy of your child's shot record to the WIC office.***

Date of WIC Certification Appointment _____

Patient's Name _____ **Birth Date** _____ **Sex** M F

Address _____ **Phone Number** (_____) _____-_____

City _____ **Zip Code** _____ **Social Security #** _____-_____-_____

Parent's/Guardian's Name _____(for infants and children only)

❑ *For Pregnant Women*

Height _____ inches **Weight** _____ lb **Date Taken** _____ (no older than 60 days)

Hemoglobin _____ **OR Hematocrit** _____ **Date Taken** _____ (must be during current pregnancy)

Expected Date of Delivery _____ **Date of First Prenatal Visit** _____ **Prepregnancy Weight** _____

❑ *For Breastfeeding and Postpartum (Non-Breastfeeding) Women*

Height _____ inches **Weight** _____ lb **Date Taken** _____(no older than 60 days)

Hemoglobin _____ **OR Hematocrit** _____ **Date Taken** _____ (must be in postpartum period)

Date of Delivery _____ **Date of First Prenatal Visit** _____ **Weight at Last Prenatal Visit** _____

❑ *For Infants and Children less than 12 months of age*

Birth Weight _____ lb _____ oz **Birth Length** _____ inches

Current Height _____ inches **Current Weight** _____ lb **Date Taken** _____ (no older than 60 days)

Hemoglobin _____ **OR Hematocrit** _____ **Date Taken** _____ (required once between 6 to 12 months **AND** once between 12 to 24 months)

❑ *For Children 1 to 5 years of age*

Height _____ inches **Weight** _____ lb **Date Taken** _____(no older than 60 days)

Hemoglobin _____ **OR Hematocrit** _____ **Date Taken** _____(once a year unless value < 11.1 Hgb or < 33% Hct, then required in 6 months)

✓ **Check all that apply.** This information assists the WIC nutritionist in determining eligibility, developing a nutrition care plan, and providing nutrition counseling. WIC staff may need to contact you or your staff to obtain more detailed medical information prior to providing WIC services.

- ❑ Medical condition (specify) _____
- ❑ High venous lead level (5 µg/dl or more) Lead level _____ Date Taken _____
- ❑ Recent major surgery, trauma, burns (specify) _____
- ❑ Food allergy (specify) _____
- ❑ Current or potential breastfeeding complications (specify) _____
- ❑ Other (specify) _____

❑ **Nutrition Counseling Requested** – specify diet prescription/order _____

WIC Local Agency Address:

Office of Public Health
Nutrition Services
628 North 4th Street, Bin #4
Baton Rouge, La 70802
Fax: 225-342-7893
Phone: 225-342-7893
www.wic.dhh.louisiana.gov

I refer this patient for WIC eligibility determination:

Signature/Title of Health Professional _____

Provider Name

Date _____

Address:

Phone:

Patient/Guardian Consent: I, the undersigned, give my provider permission to give the WIC Program any required Medican Information.