DEPARTMENT OF HEALTH AND HOSPITALS – OFFICE OF PUBLIC HEALTH

INFANT/CHILD

REFERRAL FOR WIC CERTIFICATION AND INFORMATION TRANSFER FORM

This information will be used to assist in determining nutrition risk when your patient applies for WIC benefits. Completing this form does not constitute eligibility for the program.

Patient Name: _____ Date of Birth: _____

Date medical information collected: _____ (**may not be more than 60 days old)**

*****Birth Length ___in __/8 or cm_____ Current Length____ft ____in ___/8 or cm_____

*Birth Weight___lbs ___oz or gm_____ Current Weight ____lbs ____oz or gm _____

*Weeks Gestation _____ EP Level _____ (if available)

Hgb ____ or Hct ____% (NOT REQUIRED FOR INFANTS < 9 MONTHS OF AGE AT THE INITIAL CERTIFICATION)

**This information required for less than 12 months of age and is desirable for children if it has not been previously provided.*

Please attach a copy of the immunization record or document the dates for the following immunizations:

DTP doses _____ MMR _____ Polio _____ HIB doses _____ HEP B _____

☐ This patient receives routine care through my medical practice.

☐ This patient receives acute and/or specialized health care through my medical practice.

List pertinent conditions or diagnoses:

_____

_____

Indicate nutrition problem(s) to be addressed if applicable: _____

_____

Infant/child formula type_____

Date: _____

_____
Physician, Nurse, Nutritionist's Signature and Title

_____
Community Care Referral Number

_____
Address

_____
Telephone Number **Fax Number**

WIC -17
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