Pediatric Referral

WIC Agency:

WIC ID#:

Complete this form to assist the patient with WIC eligibility, WIC services, and appropriate referrals.

Patient Name: (First) (Last)	**Date of Birth:**
Parent/Caregiver Name: (First) (Last)	**Phone Number:**

Current Height/Length (Within 60 Days) inches

Current Weight (Within 60 Days) lbs oz

Current BMI (Within 60 Days)
BMI percentile: %

Measurement Date:

Birth Weight/ Length:
lbs oz inches

Hemoglobin or Hematocrit Test is required *every 12 months* when normal *and every 6 months* when abnormal.

Hemoglobin (gm/dL) *or* Hematocrit (%)	Lab Result Date

Lead Test (recommended at 1–2 years of age):

_____ mcg/dL

Immunizations are up-to-date:

☐ Yes ☐ No ☐ Not available

Breastfeeding Assessment (birth to 12 months):

☐ Fully breastfeeding ☐ Feeding breastmilk & formula
☐ Never breastfed ☐ Discontinued breastfeeding (Date: _____)

Comments:

Provider Name (Printed): ☐ MD ☐ DO ☐ NP ☐ PA

Provider Signature:

Phone Number: **Date:**

Medical Office/Clinic Information or Stamp: