State of California — Health and Human Services Agency

California Department of Public Health --- WIC Program



Pediatric Referral



WIC Agency:

WIC ID#:

Patient Name:	(First)		(Last)			Date of Birth:
Parent/Caregiver Name:	(First)		(Last)			Phone Number:
Current Height/Length (Within 60 Days) Curr				Current We	Current Weight (Within 60 Days) Ibs oz	
Current BMI (Within 60 Days)		Meas Date:	urement		Birth Weight/ Length:	
BMI	percentile:	%				lbs oz inches
Hemoglobin or Hematocrit Test is required every 12 months when normal and every 6 months when abnormal.					Lead Test (recommended at 1–2 years of age): mcg/dL	
Hemoglobin (gm/dL) <i>or</i> Hematocrit (%)			Lab Resu	Result Date Immunizations are up-		ıp-to-date:
					🗌 Yes 🗌 No 🛛	Not available
Breastfeeding Ass (birth to 12 months) Comments:		-	reastfeeding breastfed		ing breastmilk & formula	
Provider Name (Pr Provider Signatur	-	MD	DO	NP 🗌 PA	Medical Office/Clinic	Information or Stamp:
Phone Number:			Date:			
					confidential information. Any d recipient, please contact tl	

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