



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 **Medical Office/Clinic Information or Stamp:** _____

Provider Signature: _____

Phone Number: _____ **Date:** _____