

**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