# NEW YORK STATE DEPARTMENT OF HEALTH
# DIVISION OF NUTRITION

**For WIC Use:**

| Date Mailed/ Given | Date Rec'd |
|---|---|
| Appt Date | WIC ID # |

## WIC MEDICAL REFERRAL FORM FOR WOMEN

Last Name (Print):_____  First Name: _____

Street:_____ Apt:_____ City: _____  Zip:_____

Phone: ( ) _____ - _____        Date of Birth: _____/_____/_____        On WIC Before:  Yes ☐    No ☐

Maiden Name:_____  Language(s) Spoken: _____

I authorize _____ (Health Care Provider) to release the information below to the WIC Program, and I authorize the WIC Program to release information about me to this health care provider for the purposes of coordinating my health care.  If I need to transfer to another WIC Program, I authorize the release of this information to the transferring WIC Program.  All information is considered confidential.

YOUR SIGNATURE: _____

## Health Care Provider: Please complete this section.

**PRENATAL OR POSTPARTUM:**

Gravida _____    Para_____    Multi Fetal_____

Pregravid Weight _____pounds          **Date:**

EDD _____/_____/_____

Prenatal Care Began _____/_____/_____

☐ Fetal Weight <10th Percentile for Gestational Age

**WEIGHT and HEIGHT must be less than 60 days old on the date**

**of the WIC appointment: _____/_____/_____**

**Date Taken:**

Current Weight_____pounds          _____/_____/_____

Current Height_____ inches          _____/_____/_____

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**HEMATOLOGY:**          Date Taken:

Hgb _____gm/dL **OR** Hct_____%          _____/_____/_____

Blood Lead _____mcg/dL          _____/_____/_____
(Optional)

•*Bloodwork must be taken during current pregnancy.*

•*Bloodwork must be taken after delivery for Breastfeeding/ Postpartum Women.*

**BREASTFEEDING/POSTPARTUM:** Most Recent Pregnancy

**Date of Delivery/(Termination, if any)** _____/_____/_____

Total Weight Gained_____pounds    Weeks Gestation_____

Current Infant's Birth Weight _____lb _____oz **OR** _____kg

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**SPECIFIC MEDICAL DIAGNOSIS OR NUTRITIONAL/HEALTH RISKS including ICD-9 code**

| Signature of Health Care Provider | Provider's Name (Please Print): |
|---|---|
| | Title: |
| | Medical Office/Clinic: |
| | Street: |
| | City:                                      Zip: |
| | Phone #:                                   Fax #: |
| | Date: _____/_____/_____ |

**Send Completed Form To:**