

This form **may** be used to refer patients to the WIC Program and to communicate changes in patient health information. The information provided on this form will be used by a WIC nutritionist to determine nutrition care and provide nutrition counseling.

**A separate form is required for each patient. Sections B, C and D must be completed by a health care provider.** See reverse side for additional instructions.

WIC OFFICE USE	
WIC ID	<input type="text"/>
WIC LOCAL AGENCY STAMP	

**A. Patient Information**

Patient Name \_\_\_\_\_ Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_ Sex \_\_\_\_\_  
Street Address \_\_\_\_\_ Apt. No. \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ ZIP \_\_\_\_\_ Phone ( \_\_\_\_\_ ) \_\_\_\_\_  
Preferred Language(s) \_\_\_\_\_ Parent/Guardian Name \_\_\_\_\_

**B. Patient Medical Information** *Health Care Provider: Please complete the section that is appropriate for the above named patient.*

**WOMAN**

Current Height \_\_\_\_\_ in  
Current Weight \_\_\_\_\_ lbs \_\_\_\_\_ oz  
Date Taken \_\_\_\_/\_\_\_\_/\_\_\_\_  
HGB \_\_\_\_\_g/dL or HCT \_\_\_\_\_%  
Date Taken \_\_\_\_/\_\_\_\_/\_\_\_\_  
Number of Previous Pregnancies \_\_\_\_\_  
Number of Previous Deliveries \_\_\_\_\_  
Date Prenatal Care Began \_\_\_\_/\_\_\_\_/\_\_\_\_  
 **If Pregnant:**  
Estimated Date of Delivery \_\_\_\_/\_\_\_\_/\_\_\_\_  
Number of Fetuses \_\_\_\_\_  
Pre-pregnancy Weight \_\_\_\_\_ lbs \_\_\_\_\_ oz  
 **If Postpartum:**  
Delivery/Termination Date \_\_\_\_/\_\_\_\_/\_\_\_\_  
Total Gestational Weight Gain \_\_\_\_\_ lbs \_\_\_\_\_ oz

**INFANT OR CHILD UP TO 24 MONTHS**

Birth Length \_\_\_\_\_ in or \_\_\_\_\_ cm  
Birth Weight \_\_\_\_\_ lbs \_\_\_\_\_ oz or \_\_\_\_\_ kg  
Weeks Gestation \_\_\_\_\_  
Current Length \_\_\_\_\_ in or \_\_\_\_\_ cm  
 Standing  Recumbent (<2 Years)  
Date Taken \_\_\_\_/\_\_\_\_/\_\_\_\_  
Current Weight \_\_\_\_\_ lbs \_\_\_\_\_ oz or \_\_\_\_\_ kg  
Date Taken \_\_\_\_/\_\_\_\_/\_\_\_\_  
HGB \_\_\_\_\_g/dL or HCT \_\_\_\_\_%  
Date Taken \_\_\_\_/\_\_\_\_/\_\_\_\_  
Venous Lead \_\_\_\_\_ µg/dL  
Date Taken \_\_\_\_/\_\_\_\_/\_\_\_\_  
 Not Available  
Immunizations Up to Date?  
 Yes  No  Not Available

**CHILD 2 TO 5 YEARS**

Height/Length \_\_\_\_\_ in or \_\_\_\_\_ cm  
 Standing  Recumbent (If Unable to Stand)  
Date Taken \_\_\_\_/\_\_\_\_/\_\_\_\_  
Weight \_\_\_\_\_ lbs \_\_\_\_\_ oz or \_\_\_\_\_ kg  
Date Taken \_\_\_\_/\_\_\_\_/\_\_\_\_  
HGB \_\_\_\_\_g/dL or HCT \_\_\_\_\_%  
Date Taken \_\_\_\_/\_\_\_\_/\_\_\_\_  
Venous Lead \_\_\_\_\_ µg/dL  
Date Taken \_\_\_\_/\_\_\_\_/\_\_\_\_  
 Not Available  
Immunizations Up to Date?  
 Yes  No  Not Available

**C. Specific Medical Diagnosis or Nutrition/Health Concerns**

**D. Health Care Provider Information**

Provider Name (Print) \_\_\_\_\_  
Provider Signature \_\_\_\_\_ Date \_\_\_\_/\_\_\_\_/\_\_\_\_  
Street Address \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ ZIP \_\_\_\_\_  
Phone ( \_\_\_\_\_ ) \_\_\_\_\_ Fax ( \_\_\_\_\_ ) \_\_\_\_\_

OFFICE STAMP

**E. Release of Information**

I authorize \_\_\_\_\_ (Health Care Provider) to release the information above to the WIC Program, and I authorize the WIC Program to release information about me or my child to this health care provider for the purposes of coordinating my or my child's healthcare. If my child or 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.

Patient/Parent/Guardian Signature \_\_\_\_\_ Date \_\_\_\_/\_\_\_\_/\_\_\_\_