NEW YORK STATE DEPARTMENT OF HEALTH
WIC Program

WIC Medical Referral Form

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 _____

WIC LOCAL AGENCY STAMP

Onondaga County Health Department
WIC Program
Phone: 315-435-3304
Fax: 315-435-2224
Email: OCHDWIC@ongov.net

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 ____ /____ /____

This institution is an equal opportunity provider.

Health Care Provider Instructions for Completing the WIC Medical Referral Form

Sections B, C and D must be completed by a health care provider. Please note that a separate form is needed for each patient.

A. Patient Information: This section may be completed by the health care provider, patient/parent/guardian, or WIC local agency staff. The information in this section should only pertain to the patient named at the top of the form.

B. Patient Medical Information: Complete the appropriate section for the patient named on the form.

Current height and weight measurements are to be taken no more than 60 days before the patient's WIC appointment.

Women: For all women patients complete current height and weight and the date taken; the hemoglobin or hematocrit value and the date taken; the number of previous pregnancies; the number of previous deliveries; and the date prenatal care began.

Pregnant Women: Eligible for WIC for the duration of their pregnancy and up to 6 weeks postpartum. Hemoglobin or hematocrit blood work must be taken during current pregnancy. Complete the estimated date of delivery, number of fetuses, and pre-pregnancy weight.

Postpartum/Breastfeeding Women: Non-breastfeeding postpartum women are eligible for WIC for up to 6 months after delivery/termination. Breastfeeding women are eligible for up to one year after delivery. Hemoglobin or hematocrit blood work must be taken during the postpartum period. Complete the delivery/termination date and the total weight gain during pregnancy.

Infants and Children Less than 24 Months of Age: Complete all available information. A hemoglobin or hematocrit blood work value is required once during infancy between 6 to 12 months of age (preferably between 9 to 12 months of age) **and** once between 1 to 2 years of age (preferably 6 months from the infant blood work value). If available, include a venous lead value and the date it was taken.

Children 2 to 5 Years of Age: Complete all available information. Children are eligible for WIC up to their fifth birthday. A hemoglobin or hematocrit blood work value is required once a year if found to be normal. If the value presents outside of the normal range (<11.1 hemoglobin or <33% hematocrit), the value must be tested again at 6 month intervals. If available, include a venous lead value and the date it was taken.

C. Specific Medical Diagnosis or Nutrition/Health Concerns: Note any significant medical diagnoses, history, or nutrition/health concerns. ***List any specific nutrition counseling you would like your patient to receive in this section.*** Other examples of applicable information for this section may include current or expected breastfeeding complications or food allergies. WIC staff may need to contact you or your staff to obtain more detailed medical information prior to providing WIC services.

D. Health Care Provider Information: Provider legibly prints their name, signs and dates the form. The remaining information in this section may be handwritten, or the form may be stamped with the office stamp.

E. Release of Information: The patient or parent/guardian of the patient writes the name of the health care provider on the line after "I authorize" then signs at the end of the statement, consenting to the sharing of pertinent health information between the health care provider and WIC local agency.

Give the completed form to the patient or parent/guardian to bring to the WIC appointment or mail/fax the form to the local WIC agency address shown in the top right corner of the form.

We appreciate your cooperation and partnership in serving the New York WIC population.

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