

**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 <10<sup>th</sup> 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 \_\_\_\_\_/\_\_\_\_/\_\_\_\_

**HEMATOLOGY:**

Hgb \_\_\_\_\_ gm/dL **OR** Hct \_\_\_\_\_% \_\_\_\_\_/\_\_\_\_/\_\_\_\_  
 Blood Lead \_\_\_\_\_ mcg/dL \_\_\_\_\_/\_\_\_\_/\_\_\_\_  
 (Optional)

Date Taken: \_\_\_\_\_

- 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

**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:**