Pediatric Referral

WIC Agency:

WIC ID#:

Complete this form to assist the patient with WIC eligibility, WIC services, and appropriate referrals.

Patient Name: (First) (Last) | **Date of Birth:**

Parent/Caregiver Name: (First) (Last) | **Phone Number:**

Current Height/Length (Within 60 Days) inches | **Current Weight** (Within 60 Days) lbs oz

Current BMI (Within 60 Days) BMI percentile: % | **Measurement Date:** | **Birth Weight/ Length:** lbs oz inches

Hemoglobin or Hematocrit Test is required *every 12 months* when normal *and every 6 months* when abnormal.

Hemoglobin (gm/dL) *or* Hematocrit (%)	Lab Result Date

Lead Test (recommended at 1–2 years of age):

____________ mcg/dL

Immunizations are up-to-date:

☐ Yes ☐ No ☐ Not available

Breastfeeding Assessment (birth to 12 months):

☐ Fully breastfeeding ☐ Feeding breastmilk & formula
☐ Never breastfed ☐ Discontinued breastfeeding (Date: ____________)

Comments:

CCHP Providers DO NOT need to fill out this form, if the information is entered in CCLink

Provider Name (Printed): ☐ MD ☐ DO ☐ NP ☐ PA

Medical Office/Clinic Information or Stamp:

Provider Signature:

Phone Number: | **Date:**

The information above is only for use by the intended recipient and contains confidential information. Any unauthorized review, use, disclosure or distribution is prohibited. If you are not the intended recipient, please contact the sender and destroy all copies of the original form. ***This institution is an equal opportunity provider and employer.***