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 ____/____/____

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

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:

DOH-799 (10/08)

This institution is an equal opportunity provider.