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

	Provider's Name (Please Print):
Signature of Health Care Provider	Title:
	Medical Office/Clinic:
	Street:
	City: Zip:
	Phone #: Fax #:
	Date: _____/_____/_____

Send Completed Form To: