WIC REFERRAL FORM

WIC serves women who are currently pregnant, recently pregnant in the last 6 months, or breastfeeding an infant up to 12 months, as well as infants and children up to the age of 5. WIC participants must meet income guidelines and be determined to have a nutritional risk. Please complete this form and send it to the State or Local WIC Agency as described below.

WIC BENEFITS FOR FAMILIES

Healthy foods

Breastfeeding support

Nutrition education

Health & social service referrals

WIC APPLICANT/PATIENT INFORMATION *To be completed by healthcare provider*

PARENT/GUARDIAN INFORMATION

Full Name ____________________ Date of Birth __________

Phone Number ____________________ Zip Code __________

Email Address (optional) ____________________

Preferred Language(s) ____________________

Please select Parent/Guardian status

- ☐ Pregnant Due date: ____________
- ☐ Postpartum
- ☐ Breastfeeding
- ☐ Parent, Guardian or Foster Parent

INFANT/CHILD INFORMATION

Full Name ____________________ Date of Birth __________

Height/Length: ________ ☐ in ☐ cm Date: ________

Weight: ________ ☐ lb ☐ kg Date: ________

Hemoglobin: ________ (g/dL) Date: ________

Blood Lead Level: ________ (ug/dL) Date: ________

Note: Households with more than one WIC eligible infant/child should complete a form for each infant/child.

Household nutrition, breastfeeding, or health concerns:

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HEALTHCARE PROVIDER INFORMATION

Provider or Clinic Name ____________________

Phone Number ____________________ Fax # ____________________

Email Address (optional) ____________________

Provider/Designee Signature ____________________ Date __________

REFERRAL SUBMISSION INFORMATION