State of Illinois
Department of Human Services

ILLINOIS WIC MEDICAL REFERRAL FORM

This form may be used to provide medical data to the WIC Program. Medical data may also be supplied on a provider signed medical form, letterhead, or other official medical record.

Participant Name:	Birthdate:

Current Measurements (must be within last 60 days)

Height/Length: (inches) Date of Measurement:	Weight: (lbs./.oz) Date of Measurement:
Hemoglobin or Hematocrit level: Date of lab:	Blood Lead level: Date of lab:

Birth Data (complete only if under 2 years old)

Birth Length: (inches)	Birth Weight: (lbs./.oz)	Completed weeks gestation:

Prenatal Data (complete only if pregnant)

Expected Delivery Date:	Monthly Prenatal care began:
Current Number of Prenatal Visits:	Pre-Pregnancy Weight:

Additional Comments

Health Care Provider Information

Health Care Provider's Signature:	Date:
Printed Name of Health Care Provider:	
Medical Office / Clinic Name:	
Address:	
Phone:	

Please fax, email, or have client return this form to:

This institution is an equal opportunity provider.