

# 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)  lb oz	Current Measurement Date:
		Birth Weight/Length:  lb oz inches

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

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

**Lead Test** is requested at 1-2 years of age.

Lead (mcg/dL)	Lead Test Date

**Immunizations**

(Requested for **DTaP vaccine** already administered):

DTaP Dose	Date Given (MM/DD/YY):
1	
2	
3	
4	

**Breastfeeding Assessment**  
(birth to 12 months):

- Feeding breastmilk only
- Feeding breastmilk and formula
- Never breastfed
- Discontinued breastfeeding

**Comments:**

Health care provider/medical office staff Name (Printed):	Medical Office/Clinic Information or Stamp:
Health care provider/medical office staff Signature:	
Phone Number: _____ Date: _____	

*The information above is only for use by the intended recipient and contains confidential information. Any unauthorized review, use, and 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.*