WIC Agency:

WIC ID#:

Pediatric Referral

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)	**Current Weight:** (Within 60 Days)	**Current Measurement Date:**	**Birth Weight/Length:**
inches	lb oz		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.

CDPH California Department of Public Health | CALIFORNIA WIC WOMEN, INFANTS & CHILDREN

This institution is an equal opportunity provider.

RESET FORM