

Louisiana WIC Program Medical Referral Form

Please complete shaded areas. Guardian: Please bring a copy of your child's shot record to the WIC office.

Date of WIC Certification Appointment _____

Patient's Name _____ Birth Date _____ Sex M F

Address _____ Phone Number (_____) _____ - _____

City _____ Zip Code _____ Social Security # _____ - _____ - _____

Parent's/Guardian's Name _____ (for infants and children only)

For Pregnant Women

Height _____ inches Weight _____ lb Date Taken _____ (no older than 60 days)
Hemoglobin _____ OR Hematocrit _____ Date Taken _____ (must be during current pregnancy)
Expected Date of Delivery _____ Date of First Prenatal Visit _____ Prepregnancy Weight _____

For Breastfeeding and Postpartum (Non-Breastfeeding) Women

Height _____ inches Weight _____ lb Date Taken _____ (no older than 60 days)
Hemoglobin _____ OR Hematocrit _____ Date Taken _____ (must be in postpartum period)
Date of Delivery _____ Date of First Prenatal Visit _____ Weight at Last Prenatal Visit _____

For Infants and Children less than 12 months of age

Birth Weight _____ lb _____ oz Birth Length _____ inches
Current Height _____ inches Current Weight _____ lb Date Taken _____ (no older than 60 days)
Hemoglobin _____ OR Hematocrit _____ Date Taken _____ (required once between 6 to 12 months
AND once between 12 to 24 months)

For Children 1 to 5 years of age

Height _____ inches Weight _____ lb Date Taken _____ (no older than 60 days)
Hemoglobin _____ OR Hematocrit _____ Date Taken _____ (once a year unless value < 11.1 Hgb or
< 33% Hct, then required in 6 months)

Check all that apply. This information assists the WIC nutritionist in determining eligibility, developing a nutrition care plan, and providing nutrition counseling. WIC staff may need to contact you or your staff to obtain more detailed medical information prior to providing WIC services.

- | | |
|--|--|
| <input type="checkbox"/> Medical condition (specify) _____ | <input type="checkbox"/> Food allergy (specify) _____ |
| <input type="checkbox"/> High venous lead level (5 µg/dl or more)
Lead level _____ Date Taken _____ | <input type="checkbox"/> Current or potential breastfeeding complications
(specify) _____ |
| <input type="checkbox"/> Recent major surgery, trauma, burns (specify) _____ | <input type="checkbox"/> Other (specify) _____ |

Nutrition Counseling Requested – specify diet prescription/order _____

WIC Local Agency Address:

Office of Public Health
Nutrition Services
628 North 4th Street, Bin #4
Baton Rouge, La 70802
Fax: 225-342-7893
Phone: 225-342-7893
www.wic.dhh.louisiana.gov

I refer this patient for WIC eligibility determination:

Signature/Title of Health Professional _____
Provider Name _____
Date _____
Address: _____

Phone: _____

Patient/Guardian Consent: I, the undersigned, give my provider permission to give the WIC Program any required Medical Information.