



Pediatric Referral



WIC Agency:

WIC ID#:

SECTION I: Complete this section to assist the patient with WIC eligibility, WIC services, and appropriate referrals.
Whenever a therapeutic formula is prescribed, complete both Sections I and II.

PATIENT NAME: (First)		(Last)		DATE OF BIRTH:					
CURRENT HEIGHT/LENGTH: (within 60 days)	CURRENT WEIGHT: (within 60 days)	CURRENT BMI: (within 60 days)	MEASUREMENT DATE:	BIRTH WEIGHT / LENGTH:					
inches	lbs oz	BMI percentile: %		lbs oz /	inches				
HEMOGLOBIN OR HEMATOCRIT TEST is required <u>every 12 months</u> when normal and <u>every 6 months</u> when abnormal.			LEAD TEST (recommended at 1–2 years of age): _____ mcg/dL						
<table border="1"> <thead> <tr> <th>Hemoglobin (gm/dl) or Hematocrit (%)</th> <th>Lab Result Date</th> </tr> </thead> <tbody> <tr> <td> </td> <td> </td> </tr> </tbody> </table>		Hemoglobin (gm/dl) or Hematocrit (%)	Lab Result Date			IMMUNIZATIONS are up-to-date: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not available			
Hemoglobin (gm/dl) or Hematocrit (%)	Lab Result Date								
BREASTFEEDING ASSESSMENT (birth to 12 months): <input type="checkbox"/> Fully breastfeeding <input type="checkbox"/> Never breastfed <input type="checkbox"/> Feeding breastmilk & formula <input type="checkbox"/> Discontinued breastfeeding (Date: _____)									
COMMENTS: 									
HEALTH PROFESSIONAL NAME		HEALTH PROFESSIONAL SIGNATURE		MEDICAL OFFICE / CLINIC NAME AND LOCATION OR OFFICE STAMP					
PHONE NUMBER		TODAY'S DATE							

SECTION II: Complete ALL boxes below when therapeutic formula is prescribed. Incomplete information may delay issuance of WIC foods.

DIAGNOSIS:

- Prematurity GERD or reflux Food allergy: _____
 Failure to thrive Dysphagia Other: _____

FORMULA / MEDICAL FOOD: _____

DURATION: _____ months **AMOUNT:** _____ oz / day

This prescription is: New Refill

NOTE: At 1 year of age, the patient will receive 13 quarts of cow's milk in addition to therapeutic formula unless *Do Not Give* is checked for cow's milk (see WIC Food Restrictions).

COMMENTS:

WIC FOOD RESTRICTIONS: The patient will receive WIC foods in addition to the formula prescribed. Please check all foods listed below that are NOT appropriate for the diagnosis.

Category	WIC Foods	Do Not Give	Restriction / Comment
Infants (6-11 mo)	Baby cereal		
	Baby fruits / vegetables		
(9-11 mo)	Fresh fruits / vegetables		
Children (1-5 yr)	Cow's milk		
	Cheese		
	Eggs		
	Peanut butter		
	Whole grains *		
	Cereal		
	Beans		
	Fruits / vegetables		
	Juice		
Yogurt			

* whole wheat bread, corn/wheat tortilla, brown rice, barley, bulgur, or oatmeal

HEALTH COVERAGE: Refer patient to their health plan or Medi-Cal for a medically necessary formula or medical food.

WIC only provides these products when they are NOT a covered benefit by the patient's health plan or by Medi-Cal.

Provide patient's health insurance information:	Check action taken:	If the patient requires a therapeutic formula and does NOT have health insurance, check ALL boxes below that apply:
Private insurance: _____	<input type="checkbox"/> Submitted justification to health plan	
Medi-Cal managed care: _____		
Other: _____	<input type="checkbox"/> Submitted justification to pharmacist	QUESTIONS: Call 1-888-942-9675 or 1-800-852-5770. Health Professionals: Go to www.wicworks.ca.gov ; click Health Care Professionals; then click <u>WIC contacts for MDs</u> .
Regular Medi-Cal (fee-for-service): <input type="checkbox"/> Yes <input type="checkbox"/> No		