ACCESS NYC
ACCESS NYC ID:

NEW YORK STATE DEPARTMENT OF HEALTH DIVISION OF NUTRITION

For WIC Use:	Date Mailed/ Given	Date Rec'd
	Appt Date	WIC ID #

WIC MEDICAL REFERRAL FORM FOR INFANTS AND CHILDREN

Child's Last Name (Print): ______________________ Child's First Name: ______________________

Parent/Caretaker's Name: ______________________ Street: ______________ Apt: __________

City: ______________ Zip: __________ On WIC Before: ☐ Yes ☐No Sex: ☐ M ☐ F

Phone: (____)____-_______ Child's DOB: ____/____/____ Language(s) Spoken: ______________________

I authorize ________________________ (Health Care Provider) to release the information below to the WIC Program and I authorize the WIC Program to release information about my infant/child to this health care provider for the purposes of coordinating his/her health care. If I need to transfer to another WIC Program, I authorize the release of this information to the transferring WIC Program. All information is considered confidential.

YOUR SIGNATURE:**______________________________________**

Health Care Provider: Please complete this section.

BIRTH HISTORY: ☐ SGA (<10th Weight for Gestational Age)

Birth Weight________lb ________oz **OR** __________kg

Birth Length_____in **OR** _____cm Weeks Gestation_____

WEIGHT AND HEIGHT must be less than 60 days old on the date of the

WIC appointment ____/____/____ **Date Taken:**

Current Weight_____lb _____oz **OR** _____kg ____/____/____

Current Height/Length_____in **OR** _____cm ____/____/____

Measurement Taken: ☐ Standing ☐ Recumbent (< 2 yrs)

HEMATOLOGY: **Date Taken:**

Hgb__________gm/dL **OR** Hct____ _____% ____/____/____

Blood Lead_____________mcg/dL at one year of age ____/____/____

Blood Lead_____________mcg/dL at two years of age ____/____/____

Provide marker IMMUNIZATION dates or attach a copy of record

	First	Second	Third	Fourth	Fifth
Hep B					
DTP/ DTap					
MMR					

SPECIFIC MEDICAL DIAGNOSIS OR NUTRITIONAL/HEALTH RISKS including ICD-9 code

Signature of Health Care Provider

Provider's Name (Please Print):

Title:

Medical Office/Clinic:

Street:

City: Zip:

Phone #: Fax #:

Date: ____/____/____

Send Completed Form To:

DOH-132 (10/08)

This institution is an equal opportunity provider.