



Pediatric Referral




WIC Agency: **PHFE-WIC Program**

WIC Center (_____) _____ - _____

Fax: (_____) _____ - _____

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) _____ inches	CURRENT WEIGHT: (within 60 days) _____ lbs _____ oz	CURRENT BMI: (within 60 days) _____ BMI percentile: _____ %	MEASUREMENT DATE: _____				
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" style="width:100%; border-collapse: collapse;"> <tr> <td style="width:50%;">Hemoglobin (gm/dl) <u>or</u> Hematocrit (%)</td> <td style="width:50%;">Lab Result Date</td> </tr> <tr> <td> </td> <td> </td> </tr> </table>		Hemoglobin (gm/dl) <u>or</u> 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) <u>or</u> 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: _____)							

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

<p>DIAGNOSIS:</p> <p> <input type="checkbox"/> Prematurity <input type="checkbox"/> GERD or reflux <input type="checkbox"/> Food allergy: _____ <input type="checkbox"/> Failure to thrive <input type="checkbox"/> Dysphagia <input type="checkbox"/> Other: _____ </p> <p>FORMULA / MEDICAL FOOD: _____</p> <p>DURATION: _____ months AMOUNT: _____ oz / day</p> <p>This prescription is: <input type="checkbox"/> New <input type="checkbox"/> Refill</p> <p>NOTE: At 1 year of age, the patient will receive 13 quarts of cow's milk in addition to therapeutic formula unless <i>Do Not Give</i> is checked for cow's milk (see WIC Food Restrictions).</p> <p>COMMENTS:</p>	<p>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.</p> <table border="1" style="width:100%; border-collapse: collapse;"> <thead> <tr> <th>Category</th> <th>WIC Foods</th> <th>Do Not Give</th> <th>Restriction / Comment</th> </tr> </thead> <tbody> <tr> <td rowspan="3">Infants (6–12 mo)</td> <td>Baby cereal</td> <td><input type="checkbox"/></td> <td></td> </tr> <tr> <td>Baby fruit / vegetable</td> <td><input type="checkbox"/></td> <td></td> </tr> <tr> <td>Fresh fruit / vegetable (9-12 mo only)</td> <td><input type="checkbox"/></td> <td></td> </tr> <tr> <td rowspan="7">Children (1–5 yr)</td> <td>Cow's milk / Cheese / Yogurt</td> <td><input type="checkbox"/></td> <td></td> </tr> <tr> <td>Eggs</td> <td><input type="checkbox"/></td> <td></td> </tr> <tr> <td>Peanut butter</td> <td><input type="checkbox"/></td> <td></td> </tr> <tr> <td>Whole grains *</td> <td><input type="checkbox"/></td> <td></td> </tr> <tr> <td>Cereal</td> <td><input type="checkbox"/></td> <td></td> </tr> <tr> <td>Beans</td> <td><input type="checkbox"/></td> <td></td> </tr> <tr> <td>Vegetables / fruits</td> <td><input type="checkbox"/></td> <td></td> </tr> <tr> <td>Juice</td> <td><input type="checkbox"/></td> <td></td> </tr> </tbody> </table> <p><small>* whole wheat bread, corn/wheat tortilla, brown rice, whole wheat pasta, barley, bulgur, or oatmeal</small></p>	Category	WIC Foods	Do Not Give	Restriction / Comment	Infants (6–12 mo)	Baby cereal	<input type="checkbox"/>		Baby fruit / vegetable	<input type="checkbox"/>		Fresh fruit / vegetable (9-12 mo only)	<input type="checkbox"/>		Children (1–5 yr)	Cow's milk / Cheese / Yogurt	<input type="checkbox"/>		Eggs	<input type="checkbox"/>		Peanut butter	<input type="checkbox"/>		Whole grains *	<input type="checkbox"/>		Cereal	<input type="checkbox"/>		Beans	<input type="checkbox"/>		Vegetables / fruits	<input type="checkbox"/>		Juice	<input type="checkbox"/>	
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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.

<p>Provide patient's health insurance information:</p> <p>Private insurance: _____</p> <p>Medi-Cal managed care: _____</p> <p>Other: _____</p> <p>Regular Medi-Cal (fee-for-service): <input type="checkbox"/> Yes <input type="checkbox"/> No</p>	<p>Check action taken:</p> <p><input type="checkbox"/> Submitted justification to health plan</p> <p><input type="checkbox"/> Submitted justification to pharmacist</p>	<p>If the patient requires a therapeutic formula and does NOT have health insurance, check ALL boxes below that apply:</p> <p> <input type="checkbox"/> Gave formula samples <input type="checkbox"/> Referred to Medi-Cal <input type="checkbox"/> Referred to WIC </p> <p>QUESTIONS: 1-888-942-2229</p> <p>Health Professionals: Go to www.wicworks.ca.gov; click <u>Health Care Professionals</u>; then click <u>WIC contacts for MDs</u>.</p>
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COMMENTS:

NAME – MD, PA or NP	SIGNATURE - MD, PA or NP	MEDICAL OFFICE / CLINIC NAME AND LOCATION OR OFFICE STAMP
PHONE NUMBER	TODAY'S DATE	