ACCESS NYC
ACCESS NYC ID: N/A

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 WOMEN

Last Name (Print): ______________________ First Name: ______________________

Street: ______________________ Apt:________ City: ______________________ Zip:________

Phone: ( )____-_______ Date of Birth: ____/____/____ On WIC Before: ☐ Yes ☐ No

Maiden Name: ______________________ 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 me to this health care provider for the purposes of coordinating my 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.

PRENATAL OR POSTPARTUM:

Gravida _______ Para _______ Multi Fetal ______

Pregravid Weight _________pounds **Date:**

EDD ____/____/____

Prenatal Care Began ____/____/____

☐ Fatal Weight <10th Percentile for Gestational Age

WEIGHT AND HEIGHT must be less than 60 days old on the date of the WIC appointment: ____/____/____

Date Taken:

Current Weight______pounds ____/____/____

Current Height_______inches ____/____/____

HEMATOLOGY: **Date Taken:**

Hgb_____gm/dL **OR** Hct____% ____/____/____

Blood Lead_____________mcg/dL
(Optional) ____/____/____

- *Bloodwork must be taken during current pregnancy.*
- *Bloodwork must be taken after delivery for Breastfeeding/Postpartum Women.*

BREASTFEEDING/POSTPARTUM: Most Recent Pregnancy

Date of Delivery/(Termination, if any) ____/____/____

Total Weight Gained_____pounds Weeks Gestation_____

Current Infant's Birth Weight____lb ____oz OR ____kg

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-799(10/08)

This institution is an equal opportunity provider.