# 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 or medical food is prescribed, complete both Sections I and II.***

| PATIENT NAME (First) (Last) | | | | DATE OF BIRTH: |
|---|---|---|---|---|
| CURRENT HEIGHT/LENGTH: ________ inches (within 60 days) | CURRENT WEIGHT: _____ lb _____ oz (within 60 days) | CURERNT BMI: BMI percentile: ______ % (within 60 days) | MEASUREMENT DATE | BIRTH WEIGHT/LENGTH: lb oz / inches |

**HEMOGLOBIN OR HEMATOCRIT TEST** is required every 12 months when normal and every 6 months when abnormal.

| Hemoglobin (gm/dl) or Hematocrit (%) | Lab Result Date |
|---|---|
| | |

**LEAD TEST** (recommended at 1-2 years of age): __________ mcg/dL

**IMMUNIZATIONS** are up-to-date:

☐ Yes ☐ No ☐ Not available

**BREASTFEEDING ASSESSMENT** (birth to 12 months)**:**

☐ Fully breastfeeding ☐ Never breastfed
☐ Feeding breastmilk & formula ☐ Discontinued breastfeeding Date: ________________

**SOY REQUEST FOR CHILD:** *To substitute soy milk & tofu for cow's milk & cheese, check or write a condition below:*

☐ Cow's milk protein allergy ☐ Severe lactose intolerance
☐ Vegan ☐ Other: ________________

**SECTION II:** ***Complete ALL boxes below when therapeutic formula is prescribed. Incomplete information delays 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: 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. Please see W*IC Food Restrictions*.

**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 (6-12 mo) | Baby cereal | | |
| | Baby fruit/ vegetable | | |
| Children (1-5 yr) | Cow's milk | | |
| | Cheese | | |
| | Eggs | | |
| | Peanut butter | | |
| | Whole grains * | | |
| | Cereal | | |
| | Beans | | |
| | Vegetables/fruits | | |
| | Juice | | |

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

**HEALTH COVERAGE:** ***Refer the patient to the 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: |
|---|---|
| Private insurance: ______________________<br>Medi-Cal managed care: ______________________<br>Other: ______________________ | ____ Submitted justification to health plan |
| Regular Medi-Cal ( fee-for-service) | ____ Submitted justification to pharmacist |

*If the patient requires a therapeutic formula and does NOT have health insurance, check ALL boxes below that apply:*

☐ Gave formula samples
☐ Referred to Medi-Cal
☐ Referred to WIC

**QUESTIONS:** Call 1-888-942-9675 or 1-800-852-5770.
Health professionals**:** Go to www.wicworks.ca.gov; click Health Professionals; then click WIC contacts for MDs.

**COMMENTS:**

| HEALTH PROFESSIONAL NAME | | MEDICAL OFFICE / CLINIC NAME AND LOCATION OR OFFICE STAMP |
|---|---|---|
| HEALTH PROFESSIONAL SIGNATURE | | |
| PHONE NUMBER | TODAY'S DATE | |

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