



# 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 (within 60 days) HEIGHT/LENGTH inches	CURRENT (within 60 days) WEIGHT lb oz	MEASUREMENT DATE	BIRTH WEIGHT/LENGTH: lb oz / inches						
<p><b>HEMOGLOBIN OR HEMATOCRIT TEST</b> is required <u>every 12 months</u> when normal and <u>every 6 months</u> when abnormal.</p> <table border="1" style="width:100%; border-collapse: collapse;"> <tr> <th style="width:60%;">Hemoglobin (gm/dl) or Hematocrit (%)</th> <th>Lab Result</th> <th>Date</th> </tr> <tr> <td> </td> <td> </td> <td> </td> </tr> </table>		Hemoglobin (gm/dl) or Hematocrit (%)	Lab Result	Date				<p><b>BREASTFEEDING ASSESSMENT</b> (birth to 12 months):</p> <input type="checkbox"/> Fully breastfeeding <input type="checkbox"/> Never breastfed <input type="checkbox"/> Feeding breastmilk & formula <input type="checkbox"/> Discontinued breastfeeding Date: _____	
Hemoglobin (gm/dl) or Hematocrit (%)	Lab Result	Date							
<p><b>LEAD TEST</b> (recommended at 1-2 years of age): _____ mcg/dL</p> <p><b>IMMUNIZATIONS</b> are up-to-date:</p> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not available		<p><b>SOY REQUEST FOR CHILD:</b> To substitute soy milk &amp; tofu for cow's milk &amp; cheese, check or write a condition below:</p> <input type="checkbox"/> Cow's milk protein allergy <input type="checkbox"/> Severe lactose intolerance <input type="checkbox"/> Vegan <input type="checkbox"/> Other: _____							

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

<p><b>DIAGNOSIS:</b></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><b>WIC FOOD RESTRICTIONS:</b> 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="2">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 rowspan="8">Children (1-5 yr)</td> <td>Cow's milk</td> <td><input type="checkbox"/></td> <td></td> </tr> <tr> <td>Cheese</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> <td></td> </tr> </tbody> </table> <p><small>* whole wheat bread, corn/wheat tortilla, brown rice, 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"/>		Children (1-5 yr)	Cow's milk	<input type="checkbox"/>		Cheese	<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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<p><b>FORMULA / MEDICAL FOOD:</b> _____</p> <p><b>DURATION:</b> _____ months    <b>AMOUNT:</b> _____ oz / day</p> <p>This prescription is:    <input type="checkbox"/> New    <input type="checkbox"/> Refill</p> <p><b>NOTE:</b> 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. Please see <i>WIC Food Restrictions</i>.</p>																																									

**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.**

<p><b>Provide patient's health insurance information:</b></p> <p>Private insurance: _____</p> <p>Medi-Cal managed care: _____</p> <p>Other: _____</p> <p>Regular Medi-Cal ( fee-for-service)</p>	<p><b>Check action taken:</b></p> <p>_____ Submitted justification to health plan</p> <p>_____ Submitted justification to pharmacist</p>	<p><i>If the patient requires a therapeutic formula and does NOT have health insurance, check ALL boxes below that apply:</i></p> <input type="checkbox"/> Gave formula samples <input type="checkbox"/> Referred to Medi-Cal <input type="checkbox"/> Referred to WIC
<p><b>QUESTIONS:</b> Call 1-888-942-9675 or 1-800-852-5770.                  Health professionals: Go to <a href="http://www.wicworks.ca.gov">www.wicworks.ca.gov</a>; click <u>Health Professionals</u>; then click <u>WIC contacts for MDs</u>.</p>		

**COMMENTS:**

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