Pennsylvania WIC Pediatric Referral Form

Send completed forms to: _____

Parent/Guardian Name: _____

Child's Name: _____ **Child's Date of Birth**: _____

Child's Ethnicity: **Child's Gender:** ☐ Female ☐ Male

☐ Hispanic or Latino ☐ Not Hispanic or Latino

Child's Race (Check all that apply):

☐ American Indian/Alaska Native ☐ Asian ☐ Black ☐ Native Hawaiian/Pacific Islander ☐ White

Street Address: _____ **City**: _____

Zip Code: _____ **County**: _____

Phone Number: _____ **E-mail**: _____

Anthropometric Measurements	Current Bloodwork	Birth Information
	Required for children over 9 months	Required for children under 2 years
Current weight: _____		
Current height: _____	Hemoglobin: _____g/d/l	Gestational Age: _____
	or	Birth Weight: _____
For infants under 2 include	Hematocrit: _____%	Birth Length: _____
Head Circumference: _____	Lead Screening: _____ mcg/dl	Head Circumference: _____
		Delivery Method: _____
Date Measured: _____	Date of Blood Test: _____	

Immunization Records are required on all children under age 2. Please provide copy of records.
☐ Records Included ☐ Records Not Available

Food Allergies/Intolerances: _____

Medications/Supplements: _____

Other pertinent medical information: _____

_____

Infant Feeding: ☐ Breastfeeding ☐ Formula Feeding ☐ Both

Formula

WIC provides Similac Advance, Sensitive, Total Comfort, Spit Up, and Soy Isomil. At this time, WIC does not cover Similac "Pro" formulas. WIC does not provide other brands of standard infant formulas. If this infant/child requires another Similac formula or a special formula due to a medical condition, the formula must be approved by the PA WIC Program.
Use the *Pennsylvania WIC Program Formula Authorization Form*.

Healthcare Facility Name: _____ **Phone**: _____

Signature/Title: _____ **Date**: _____