



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 is prescribed, complete both Sections I and II.

PATIENT NAME: (First)		(Last)		DATE OF BIRTH:					
CURRENT HEIGHT/LENGTH: (within 60 days)	CURRENT WEIGHT: (within 60 days)	CURRENT BMI: (within 60 days)	MEASUREMENT DATE:	BIRTH WEIGHT / LENGTH:					
inches	lbs oz	BMI percentile: %		lbs oz /	inches				
<p>HEMOGLOBIN OR HEMATOCRIT TEST 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> <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			<p>BREASTFEEDING ASSESSMENT (birth to 12 months):</p> <p><input type="checkbox"/> Fully breastfeeding <input type="checkbox"/> Never breastfed</p> <p><input type="checkbox"/> Feeding breastmilk & formula <input type="checkbox"/> Discontinued breastfeeding</p> <p style="text-align: right;">Date: _____</p> <p>SOY REQUEST FOR CHILD: <i>To substitute soy milk & tofu for cow's milk & cheese, check or write a condition below:</i></p> <p><input type="checkbox"/> Cow's milk protein allergy <input type="checkbox"/> Severe lactose intolerance</p> <p><input type="checkbox"/> Vegan <input type="checkbox"/> Other: _____</p>		
Hemoglobin (gm/dl) <u>or</u> Hematocrit (%)	Lab Result Date								
<p>LEAD TEST (recommended at 1-2 years of age): _____ mcg/dL</p> <p>IMMUNIZATIONS are up-to-date:</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not available</p>									
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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SECTION II: Complete ALL boxes below when therapeutic formula is prescribed. Incomplete information may delay 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 (see WIC 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:

Private insurance: _____

Medi-Cal managed care: _____

Other: _____

Regular Medi-Cal (fee-for-service)

Check action taken:

_____ Submitted justification to health plan

_____ 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 Care Professionals](#); then click [WIC contacts for MDs](#).