CALIFORNIA WIC WOMEN, INFANTS & CHILDREN Families grow healthy with WIC

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) inches	CURRENT WEIGHT: (within 60 days) lbs oz	CURRENT BMI: (within 60 days) BMI percentile: %	MEASUREMENT DATE:	BIRTH WEIGHT / LENGTH: lbs 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: _____

COMMENTS:

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

 | CDPH 247A Rev 03/13 #930029

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:	**Check action taken:**
Private insurance: _____ **Medi-Cal managed care:** _____ **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 Care Professionals; then click WIC contacts for MDs.

