Pediatric Referral and Special Dietary Requests

WIC Agency:

WIC ID #:

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☐ **Routine referral (Complete Section I only)** ☐ **Special dietary request (Complete Sections I and II)**

SECTION I: Complete this section to assist WIC with patient eligibility, providing WIC services, and making appropriate referrals.

PATIENT NAME (First) (Last)			DATE OF BIRTH:
CURRENT HEIGHT/LENGTH: inches	CURRENT WEIGHT: lb oz	DATE OF MEASUREMENTS	BIRTH WEIGHT/LENGTH: lb oz / inches

Hgb or hct test is required annually and every 6 months if abnormal.

Recommended	Recent Hgb or Recent Hct		Date of test
6 – 13 mo	.	%	
> 13 – 23 mo	.	%	
> 23 – 35 mo	.	%	
> 35 – 47 mo	.	%	

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

IMMUNIZATIONS (up-to-date): ☐ Yes ☐ No ☐ Not available

BREASTFEEDING PLAN:

☐ Fully breastfeeding
☐ Combination feeding breastmilk and formula
☐ Discontinued breastfeeding Date: ________________
☐ Never breastfed

SOY MILK & TOFU REQUEST (one yr or older): Check a qualifying condition to substitute soy milk & tofu for cow's milk & cheese.

☐ Cow's milk allergy
☐ Vegan
☐ Other:
☐ Severe lactose intolerance
☐ Does not apply

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

SECTION II: ONLY complete if there are special dietary needs. Incomplete information may delay issuance of WIC foods.

DIAGNOSIS:

☐ Prematurity
☐ Failure to thrive
☐ Allergy: ________________
☐ Other: ________________________________
☐ Dysphagia

FORMULA/MEDICAL FOOD NAME:

DURATION	AMOUNT
months	________ oz / day

Refer patient to health plan or Medi-Cal for medically necessary formulas and medical foods. WIC only provides when NOT AVAILABLE FROM OTHER SOURCES.

HEALTH COVERAGE:

Type	Name of Health Plan	Check Action Taken
Medi-Cal Fee-for-service	Not applicable	___ Submitted justification to pharmacist
Medi-Cal Managed Care		___ Submitted justification to health plan
Healthy Families		
Private Insurance		

CHECK ALL THAT APPLY to the provision of a prescribed formula/medical food:

☐ Referred patient to health plan
☐ No insurance; referred patient to Medi-Cal
☐ Gave formula samples
☐ Not eligible for Medi-Cal; referred to WIC (WIC requires Rx every 3 months)

WIC FOOD RESTRICTIONS:

Please check all WIC foods that are NOT APPROPRIATE for this patient. The amounts issued per month are listed below.

***INFANT (6-11* mo) – DO NOT provide** the WIC foods checked below:

☐ Infant cereals, 24 oz
☐ Infant fruits and vegetables, up to 256 oz

***CHILD (1-5 yr)* – DO NOT provide** the WIC foods checked below:

☐ Cow's milk, 13 qt
☐ Cheese, 1 lb
☐ Eggs, 1 dozen
☐ Peanut butter, 18 oz
☐ Whole grains*, 2 lb
☐ Dry beans, peas or lentils, 1 lb
☐ Breakfast cereals, 36 oz
☐ Vegetables and fruits
☐ Juice, 128 fl oz

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

QUESTIONS:

Health care professionals only: Call 916-928-8652.
WIC staff only: Use 916-440-5581 to fax State Agency.

This institution is an equal opportunity provider and employer.