

## Pediatric Referral



| WIC Agency: |  |  |
|-------------|--|--|
|             |  |  |
|             |  |  |
|             |  |  |
| MIC ID!!    |  |  |
| 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.

| Whenever a therapeutic formula is prescribed, complete both Sections I <u>and</u> II. |   |                               |   |   |   |                |                         |                |        |  |  |
|---|---|-------------------------------|---|---|---|----------------|-------------------------|----------------|--------|--|--|
| PATIENT NAME: (First)   | IE: (First) (Last)                              |                               |   |   | DA <sup>-</sup>   | DATE OF BIRTH: |                         |                |        |  |  |
|   |   |                               |   |   |   |                |                         |                |        |  |  |
|   | CURRENT WEIGHT:<br>(within 60 days)             | I                             |   |   | MEASUREMENT DATE:   |                | BIRTH WEIGHT / LENGTH:  |                |        |  |  |
| inches  | (within 60 days)                                |                               |   | ntile: %  |   |                | Ibs                     | OZ             | inches |  |  |
| HEMOGLOBIN OR HEMATOCRIT  | TEST is required a                              | avary 12 months               | when normal   |   |   |                |                         |                |        |  |  |
| and every 6 months when abnorm  |   | every 12 months               | Wilch Horman  |   | LEAD TEST (recommer                                       | nded at 1-     | -2 years of age): _     | mcg/           | /dL    |  |  |
| and every o moners when abnormal.   |   |                               |   |   |   |                |                         |                |        |  |  |
| Hemoglobin (gm/dl) <u>or</u> Hematocrit (%) Lab Result Date                           |   |                               |   | IMMUNIZATIONS are up-to-date:   |   |                |                         |                |        |  |  |
|   |   |                               |   | ☐ Yes ☐ No ☐ I  | Not availa  | ble            |                         |                |        |  |  |
|   |   |                               |   |   |   |                |                         |                |        |  |  |
| BREASTFEEDING ASSESSMENT (  | oirth to 12 months                              | s):                           |   |   |   |                |                         |                |        |  |  |
| Fully breastfeeding   | Never breastfed                                 | 1                             | eeding breastmilk &   | formula   | Discontinued  | hreastfee      | ding (Date:             |                | ,      |  |  |
| I any breastreeding   |   |                               | ocanig broadtriiik a  | Tormula   | Discontinued  | breastreet     | ung (butc.              |                |        |  |  |
| SECTION II: Complete ALL bo   | oxes below wh                                   | en therapeut                  | ic formula is p   | rescribed.  | Incomplete informa  | tion ma        | y delay issuan          | ice of WIC     | foods. |  |  |
| DIAGNOSIS:  |   |                               |   | WIC FOOD  | RESTRICTIONS: The pat                                     | ient will r    | receive WIC foods       | in addition to | o the  |  |  |
| Dramaturity CERD of   |   | ood allarmu                   |   | formula prescribed. Please check all foods listed below that are NOT appropriate                                    |   |                |                         |                |        |  |  |
|   | _   | ood allergy:                  |   | for the diag  | gnosis.   |                |                         |                |        |  |  |
| Failure to thrive Dyspha  | igia 📋 O  | other:                        |   | Category  | WIC Foods   | Do Not         | Restriction             | n / Comment    |        |  |  |
| FORMULA / MEDICAL FOOD:   |   |                               |   | ,   |   | Give           |                         |                |        |  |  |
|   |   |                               | _   | Infants<br>(6–12 mo)  | Baby cereal   |                |                         |                |        |  |  |
| <b>DURATION:</b> months <b>AMOUNT:</b> oz / day                                       |   |                               |   | Baby fruit / vegetable  |   |                |                         |                |        |  |  |
| This prescription is: New   | Refill  |                               |   | Children<br>(1–5 yr)  | Cow's milk<br>Cheese                                      |                |                         |                |        |  |  |
| inis prescription is.   | Keiiii  |                               |   | (, , , , ,  | Eggs  |                |                         |                |        |  |  |
| NOTE: At 1 year of age, the patient   | will receive 13 qua                             | arts of cow's milk            | c in  |   | Peanut butter   |                |                         |                |        |  |  |
| addition to therapeutic formula unless <i>Do Not Give</i> is checked for cow's milk   |   |                               |   | Whole grains *  |   |                |                         |                |        |  |  |
| (see WIC Food Restrictions).  |   |                               |   |   | Cereal  |                |                         |                |        |  |  |
| COMMENTS:   |   |                               |   | Beans   |   |                |                         |                |        |  |  |
|   |   |                               |   | Vegetables / fruits   |   |                |                         |                |        |  |  |
|   |   |                               |   | Juice   |   |                |                         |                |        |  |  |
|   |   |                               |   | Yogurt  |   |                |                         |                |        |  |  |
|   |   |                               |   |   | at bread, corn/wheat tortilla                             | , brown rice   | e, barley, bulgur, or o | atmeal         |        |  |  |
| HEALTH COVERAGE: Refer p<br>WIC only provides these products                          |   |                               |   |   |   | ıla or m       | edical food.            |                |        |  |  |
| Provide patient's health insurance  | alth insurance information: Check action taken: |                               |   | If the patient requires a therapeutic formula and does NOT have health insurance, check ALL boxes below that apply: |   |                |                         |                |        |  |  |
|   |   |                               |   |   |   | v cnacaj       | PP19.                   |                |        |  |  |
| Private insurance:  |   | Suhmitt                       | ed justification  | _   | ormula samples  |                |                         |                |        |  |  |
| Medi-Cal managed care:  |   | to healt                      | •   |   | d to Medi-Cal   |                |                         |                |        |  |  |
| Other:  |   |                               |   | Referre   | d to WIC  |                |                         |                |        |  |  |
|   |   |                               |   | QUESTION  | <b>S</b> : Call 1-888-942-9675 o                          | r 1-800-8      | 52-5770.                |                |        |  |  |
| Regular Medi-Cal (fee-for-service): Yes No Submitted justification to pharmacist      |   |                               | Health Professionals: Go to <a href="https://www.wicworks.ca.gov">www.wicworks.ca.gov</a> ; click <a href="https://www.wicworks.ca.gov">Health Care Professionals</a> ; then click <a href="https://www.wicworks.ca.gov">WIC contacts for MDs</a> . |   |   |                |                         |                |        |  |  |
|   |   |                               |   |   |   |                |                         |                |        |  |  |
| COMMENTS:   |   |                               |   |   |   |                |                         |                |        |  |  |
|   |   |                               |   |   |   |                |                         |                |        |  |  |
| HEALTH PROFESSIONAL NAME  | HE  | HEALTH PROFESSIONAL SIGNATURE |   |   | MEDICAL OFFICE / CLINIC NAME AND LOCATION OR OFFICE STAMP |                |                         |                |        |  |  |
| PHONE NUMBER TODAY'S DATE   |   |                               |   |   |   |                |                         |                |        |  |  |
|   |   |                               | . JUNI JUNIE  |   |   |                |                         |                |        |  |  |

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