CLINICAL FORM TEMPLATE

WIC medical referral form

For a licensed provider to certify nutritional risk and refer a patient to the local WIC agency. Missing fields delay enrollment.

1. PATIENT INFORMATION

Patient full name (last, first, middle) | Date of birth (mm/dd/yyyy) | Sex | Medical record number

Street address | City | State / ZIP

Parent or guardian (if the patient is a minor) | Phone | Email | Preferred language

2. PARTICIPANT CATEGORY

☐ Pregnant — due date _____ ☐ Postpartum (not breastfeeding) ☐ Breastfeeding ☐ Infant (under 12 months)
☐ Child (1 to 5 years)

Breastfeeding status: ☐ Currently breastfeeding ☐ Plans to breastfeed ☐ Breast milk and formula ☐ Not breastfeeding

3. MEASUREMENTS AND LABORATORY VALUES

Date measured | Weight (lb / kg) | Length or height (in / cm) | Head circumference (under 2) | Weight-for-length percentile | BMI or BMI-for-age percentile

Hemoglobin (g/dL) | Hematocrit (%) | Date of blood work | Method and site (venous, capillary, point of care)

Record measurements taken within the past 60 days. Write "not taken" rather than leaving a field blank.

4. NUTRITIONAL RISK

☐ Anemia, confirmed by hemoglobin or hematocrit
☐ Overweight or obesity
☐ Inadequate dietary intake
☐ Gestational diabetes
☐ Inadequate weight gain in pregnancy
☐ History of preterm birth or low birth weight
☐ Underweight or low weight-for-length
☐ Inadequate growth or failure to thrive
☐ Infant feeding difficulty
☐ Hypertension during pregnancy
☐ Multiple gestation
☐ History of fetal or neonatal loss

Other risk, or your state's nutritional risk code(s)

Clinical notes supporting the risk above

5. DIAGNOSED CONDITIONS, MEDICATION AND DIET

Diagnosed medical conditions relevant to nutrition (add ICD-10 codes where available)

Medication, supplements and vitamins

Food allergies and intolerances

Special formula or medical food requested (name, amount, duration)

6. PROVIDER CERTIFICATION

I have assessed this patient and certify that the nutritional risk recorded above reflects my clinical judgment. I authorize release of this information to the WIC agency named by the patient or guardian.

Provider name (print) | Credential | NPI | Practice name | Phone

Provider signature | Date signed (mm/dd/yyyy) | Secure fax or email for follow-up questions

7. FOR WIC AGENCY USE ONLY

Date received | Received by | Certification appointment date | Follow-up needed