Women, Infants, and Children (WIC) Program Referral Form

Parent/Guardian: Please complete this section	
Child's name: Address: Phone: Child on WIC before? ☐ Yes ☐ No I authorize **Greater Roslindale Medical and Dental Center** to release to WIC the information below and I authorize WIC to release information about my child to this health center, doctor, or nurse for purposes of coordinating care.	Your Name (print) _____ Child's date of birth: Language Spoken: Your Signature:_____

Clinician: Please complete this section – WIC eligibility will depend on this information.

One Blood test required (blood work required for children > 6 mo.):	
HGB/HCT: Redrawn today? LEAD: Weight and height must be less than 60 days old on date of WIC appointment. Current Weight Current Height: First Visit Only: Birth Weight: Birth Height::	Please note all that apply: ☐ Repeated GI disturbances (infant only), mo/yr: 1) date ___/___ 2) ___/___ 3) ___/____ ☐ Infectious disease, specify: ☐ Food Allergy or intolerance, specify:_____ ☐ Traumatic injury/burns?surgery, mo/yr:____ /____ ☐ Iron deficiency anemia ☐ Lead poisoning ☐ Congenital anomaly or developmental delay impairing feeding/utilization of nutrients ☐ Chronic ear/upper resp infections within last year, mo/yr: 1) date ___/___ 2) ___/___ 3)___/ ___ ☐ Mental illness/retardation ☐ Mother/caretaker with mental illness/retardation ☐ Mother/caretaker with substance abuse, specify:_____ ☐ Chronic nutr-related medical condition, specify: ☐ Pregnant Woman_____ ☐ Other, specify; _____

Immunizations:	
	☐ Please send copy of WIC assessment ☐ Please call me about this patient

_____ Date:_____

Signature