Section I: Instructions for Pediatric Referral Form

Provide Hgb and Hct level(s) for the current age. Write the results in the row that reflects the age of the infant/child and the date of the test.

After doctor discusses breastfeeding with the mother, doctor checks if there are any contraindications to breastfeeding and the mother's breastfeeding plan.

The local WIC agency will provide this information.

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

Pediatric Referral Form

South Los Angeles Health Projects WIC

WIC ID#:_____

The information below is only for use by the intended recipient and contains confidential information. Any unauthorized review, use, disclosure or distribution is prohibited. If you are not the intended recipient, please contact the sender and destroy all copies of the original form. If you have questions, contact your local WIC agency at (310) 661-3080. ***WIC PROMOTES AND SUPPORTS EXCLUSIVE BREASTFEEDING.***

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

MEDICAL CONDITION(S):

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	.	%	
> 47 – 60 mo	.	%	

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

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

BREASTFEEDING PLAN:

Are there contraindications to exclusive breastfeeding? ___ yes ___ no

☐ Fully breastfeeding ☐ Discontinued breastfeeding Date: _____

☐ Combination feeding breastmilk and formula ☐ Never breastfed

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

☐ Cow's milk allergy
☐ Severe lactose intolerance
☐ Vegan
☐ Other: _____

HEALTH PROFESSIONAL NAME

HEALTH PROFESSIONAL SIGNATURE

PHONE NUMBER | **TODAY'S DATE**

MEDICAL OFFICE / CLINIC NAME AND LOCATION OR OFFICE STAMP

WIC refers children to their health care provider for blood lead levels at one year old or older.

Include provider's signature or signature stamp.

Doctor checks qualifying condition for substituting soy milk and tofu for milk and cheese. Cow's milk and cheese will NOT be provided.

If the "other" box is checked, please write a specific qualifying condition. *A personal preference is not a qualifying condition

Developed by the California WIC Program, revised by LA BioMed WIC 09/2009