A nutrition program for those who are:

- Pregnant
- Breastfeeding
- Postpartum
- Infants and children up to age 5

WIC stands for **Women, Infants and Children**. It's a New York State nutrition program that can help you buy a variety of foods to keep you and your baby healthy. WIC can also teach you about healthy eating, exercise, and breastfeeding. Families who are enrolled in the WIC program will get an eWIC card, like a debit card with a PIN, to buy WIC-approved foods at grocery stores that accept WIC.

Contact a WIC office near you to find out if you're eligible. To enroll you will need the following:

What to Bring:	Choose From:
1. **WIC Referral Form**	• Ask your nutritionist for a form.
2. **Photo ID**	• A New York State ID card **or** a passport
3. **Proof of Income** (choose 1)	• Medicaid card • Budget letter • 1 month's paystubs • Proof that your PCAP insurance is pending
4. **Proof of Address**	• Recent utility or phone bill • Anything official that you get in the mail

Manhattan WIC Centers	Address	Phone Number
East Harlem Council for Human Services, Inc.	2253 3rd Avenue, 4th Fl.	212-289-6650
Gouverneur Hospital	227 Madison Street, 3rd Fl.	212-238-7145
Harlem Hospital	506 Lenox Avenue, Ronald H. Brown Bldg, Rm #1061	212-939-2730
New York Downtown Hospital	69 Gold Street, Lobby Level	212-312-5831
New York Presbyterian Medical Center	549 West 180th Street, 2nd Fl.	212-928-0307
Institute for Family Health	1824 Madison Avenue, 2nd Fl.	212-423-4201
St. Luke's - Roosevelt Hospital Center	1111 Amsterdam Avenue, Travers Bldg	212-523-3446
William F. Ryan Community Health Center	801 Amsterdam Avenue, 2nd Fl.	212-865-0410
Eastside WIC (Bellevue Hospital)	462 First Avenue, Ground Fl. C&D Bldg	212-562-6124

NEW YORK STATE DEPARTMENT OF HEALTH
WIC Program

WIC Medical Referral Form

This form **may** be used to refer patients to the WIC Program and to communicate changes in patient health information. The information provided on this form will be used by a WIC nutritionist to determine nutrition care and provide nutrition counseling.

A separate form is required for each patient. Sections B, C and D must be completed by a health care provider. See reverse side for additional instructions.

WIC OFFICE USE

WIC ID

WIC LOCAL AGENCY STAMP

A. Patient Information

Patient Name_______________ Date of Birth ____ /____ /____ Sex_______________

Street Address_______________ Apt. No.___________

City_______________ State______ ZIP___________ Phone (_______) _______________

Preferred Language(s) _______________ Parent/Guardian Name _______________

B. Patient Medical Information *Health Care Provider: Please complete the section that is appropriate for the above named patient.*

☐ **WOMAN**

Current Height _______ in
Current Weight _______ lbs _______ oz
Date Taken _____ /_____ /_____

HGB _______g/dL *or* HCT _______%
Date Taken _____ /_____ /_____

Number of Previous Pregnancies ______
Number of Previous Deliveries ______
Date Prenatal Care Began _____ /_____ /_____

☐ **If Pregnant:**
Estimated Date of Delivery _____ /_____ /_____
Number of Fetuses _______
Pre-pregnancy Weight ______ lbs ______ oz

☐ **If Postpartum:**
Delivery/Termination Date ___ /___ /___
Total Gestational Weight Gain _____ lbs _____ oz

☐ **INFANT OR CHILD UP TO 24 MONTHS**

Birth Length ______ in *or* ______ cm
Birth Weight _____ lbs _____ oz *or* _____ kg
Weeks Gestation ______

Current Length ______ in *or* ______ cm
☐ Standing ☐ Recumbent (<2 Years)
Date Taken _____ /_____ /_____

Current Weight ___ lbs ___ oz *or* ___ kg
Date Taken _____ /_____ /_____

HGB _______ g/dL *or* HCT _______ %
Date Taken _____ /_____ /_____

Venous Lead _______ µg/dL
Date Taken _____ /_____ /_____
☐ Not Available

Immunizations Up to Date?
☐ Yes ☐ No ☐ Not Available

☐ **CHILD 2 TO 5 YEARS**

Height/Length _____ in *or* _____ cm
☐ Standing ☐ Recumbent (If Unable to Stand)
Date Taken _____ /_____ /_____

Weight ______ lbs ______ oz *or* ______ kg
Date Taken _____ /_____ /_____

HGB _______ g/dL *or* HCT _______ %
Date Taken _____ /_____ /_____

Venous Lead _______ µg/dL
Date Taken _____ /_____ /_____
☐ Not Available

Immunizations Up to Date?
☐ Yes ☐ No ☐ Not Available

C. Specific Medical Diagnosis or Nutrition/Health Concerns

____
____

D. Health Care Provider Information

Provider Name (Print) _______________

Provider Signature_______________Date _____ /_____ /_____

Street Address _______________

City_______________ State______ ZIP_______________

Phone (_______)_______________ Fax (_______) _______________

OFFICE STAMP

E. Release of Information

I authorize_______________ (Health Care Provider) to release the information above to the WIC Program, and I authorize the WIC Program to release information about me or my child to this health care provider for the purposes of coordinating my or my child's healthcare. If my child or I need to transfer to another WIC Program, I authorize the release of this information to the transferring WIC Program. All information is considered confidential.

Patient/Parent/Guardian Signature_______________ Date _____ /_____ /_____

This institution is an equal opportunity provider.

Health Care Provider Instructions for Completing the WIC Medical Referral Form

Sections B, C and D must be completed by a health care provider. Please note that a separate form is needed for each patient.

A. Patient Information: This section may be completed by the health care provider, patient/parent/guardian, or WIC local agency staff. The information in this section should only pertain to the patient named at the top of the form.

B. Patient Medical Information: Complete the appropriate section for the patient named on the form.

Current height and weight measurements are to be taken no more than 60 days before the patient's WIC appointment.

Women: For all women patients complete current height and weight and the date taken; the hemoglobin or hematocrit value and the date taken; the number of previous pregnancies; the number of previous deliveries; and the date prenatal care began.

Pregnant Women: Eligible for WIC for the duration of their pregnancy and up to 6 weeks postpartum. Hemoglobin or hematocrit blood work must be taken during current pregnancy. Complete the estimated date of delivery, number of fetuses, and pre-pregnancy weight.

Postpartum/Breastfeeding Women: Non-breastfeeding postpartum women are eligible for WIC for up to 6 months after delivery/termination. Breastfeeding women are eligible for up to one year after delivery. Hemoglobin or hematocrit blood work must be taken during the postpartum period. Complete the delivery/termination date and the total weight gain during pregnancy.

Infants and Children Less than 24 Months of Age: Complete all available information. A hemoglobin or hematocrit blood work value is required once during infancy between 6 to 12 months of age (preferably between 9 to 12 months of age) **and** once between 1 to 2 years of age (preferably 6 months from the infant blood work value). If available, include a venous lead value and the date it was taken.

Children 2 to 5 Years of Age: Complete all available information. Children are eligible for WIC up to their fifth birthday. A hemoglobin or hematocrit blood work value is required once a year if found to be normal. If the value presents outside of the normal range (<11.1 hemoglobin or <33% hematocrit), the value must be tested again at 6 month intervals. If available, include a venous lead value and the date it was taken.

C. Specific Medical Diagnosis or Nutrition/Health Concerns: Note any significant medical diagnoses, history, or nutrition/health concerns. ***List any specific nutrition counseling you would like your patient to receive in this section.*** Other examples of applicable information for this section may include current or expected breastfeeding complications or food allergies. WIC staff may need to contact you or your staff to obtain more detailed medical information prior to providing WIC services.

D. Health Care Provider Information: Provider legibly prints their name, signs and dates the form. The remaining information in this section may be handwritten, or the form may be stamped with the office stamp.

E. Release of Information: The patient or parent/guardian of the patient writes the name of the health care provider on the line after "I authorize" then signs at the end of the statement, consenting to the sharing of pertinent health information between the health care provider and WIC local agency.

Give the completed form to the patient or parent/guardian to bring to the WIC appointment or mail/fax the form to the local WIC agency address shown in the top right corner of the form.

We appreciate your cooperation and partnership in serving the New York WIC population.

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