New York State WIC
Together Growing Stronger Families

একটি পুষ্টি কর্মসূচি তাদের জন্য যারা:

- গর্ভবতী
- বুকের দুধ খাওয়াচ্ছেন
- প্রসবোত্তর
- নবজাতক এবং ৫ বছর বয়স পর্যন্ত শিশু

WIC এর অর্থ নারী, নবজাতক ও শিশু। এটি নিউ ইয়র্ক স্টেটের একটি পুষ্টি কর্মসূচি যা আপনাকে এবং আপনার শিশুর স্বাস্থ্য বজায় রাখতে বিভিন্ন ধরনের খাবার কিনতে আপনাকে সাহায্য করতে পারে। এছাড়াও WIC আপনাকে স্বাস্থ্যকর খাবার, ব্যায়াম, বুকের দুধ খাওয়ানো সম্পর্কে শেখাতে পারে। WIC কর্মসূচিতে তালিকাভুক্ত পরিবার ডেবিট কার্ডের মতো পিনসহ একটি eWIC কার্ড পাবেন, যা দিয়ে WIC গ্রহণ করে এমন মুদি দোকান থেকে WIC-অনুমোদিত খাবার কেনা যাবে।

আপনি যোগ্য কিনা তা জানতে আপনার নিকটস্থ WIC অফিসে যোগাযোগ করুন। তালিকাভুক্ত হতে আপনার নিম্নলিখিত কাগজপত্র প্রয়োজন হবে:

কী আনতে হবে:	বাছাই ফরম:
1. **WIC রেফারেল ফরম**	• আপনার পুষ্টিবিদের কাছে ফরম চান।
2. **ছবিসহ ID**	• নিউইয়র্ক স্টেট ID কার্ড অথবা পাসপোর্ট
3. **আয়ের প্রমাণ (১ বাছুন)**	• মেডিকেইড কার্ড • বাজেট চিঠি • ১ মাসের পেস্টাব • আপনার প্রসবপূর্ব যত্ন সহায়তা পরিষেবা (PCAP) বিমা অপেক্ষমান রয়েছে তার প্রমাণ
4. **ঠিকানার প্রমাণ**	• সাম্প্রতিক ইউটিলিটি বা ফোন বিল, অথবা আপনি ইমেইলে পান এমন অফিশিয়াল যেকোনো কিছু

ব্রুকলিন WIC কেন্দ্র	ঠিকানা	ফোন নম্বর
Public Health Solutions	335 Central Avenue	718-919-0044
Bedford Stuyvesant Family Health Center	20 New York Avenue, 1st Fl.	718-857-4375
Brookdale Hospital and Medical Center	465 New Lots Avenue	718-240-6445
Brooklyn Hospital	485 Coney Island Avenue	718-282-8904 ext. 235
Brownsville Community Development Corp.	408 Rockaway Avenue, 2nd Fl.	718-345-6366
Coney Island Hospital	(Sandy Site) 2880 West 12th Street	1-844-872-6639
East NY Diagnostic & Treatment Center	2094 Pitkin Avenue	718-240-0470
Brooklyn Hospital Center	535 Empire Boulevard	718-467-0010
Maimonides Medical Center	5613 Fort Hamilton Parkway	718-854-3190
Opportunity Development Association of Williamsburg	12 Heyward Street	718-852-1917
Lutheran Medical Center	Sunset Park Family Health Center, 6025 6th Avenue	718-630-7161
Northern Brooklyn Health Network	760 Broadway, Rm 2B 320	718-963-8559
Wyckoff Heights Medical Center	316A Himrod Street, Ste 1	718-963-6471
Yeled v'Yalda Early Childhood Center	1312 38th Street 3080	718-686-3799
Jamaica Hospital	Atlantic Avenue	718-647-0240
Ocean Avenue WIC Center	2555 Ocean Avenue, 2nd Fl.	718-332-4059
Sunset Park WIC Center	462 36th Street, 2nd Fl. (between 4th and 5th Avenues)	718-942-6240

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 ____ /____ /____

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.