



Pennsylvania WIC Pediatric Referral Form

Send completed forms to:

Parent/Guardian Name: _____

Child's Name: _____

Child's Date of Birth: _____

Child's Ethnicity:

Child's Gender:

☐ Female

☐ Male

☐ Hispanic or Latino ☐ Not Hispanic or Latino

Child's Race (Check all that apply):

☐ American Indian/Alaska Native ☐ Asian ☐ Black ☐ Native Hawaiian/Pacific Islander ☐ White

Street Address: _____ **City:** _____

Zip Code: _____ **County:** _____

Phone Number: _____ **E-mail:** _____

Anthropometric Measurements	Current Bloodwork	Birth Information
Current weight: _____	Required for children over 9 months	Required for children under 2 years
Current height: _____	Hemoglobin: _____ g/d/l	Gestational Age: _____
For infants under 2 include	or	Birth Weight: _____
Head Circumference: _____	Hematocrit: _____ %	Birth Length: _____
Date Measured: _____	Lead Screening: _____ mcg/dl	Head Circumference: _____
	Date of Blood Test: _____	Delivery Method: _____
Immunization Records are required on all children under age 2. Please provide copy of records. <input type="checkbox"/> Records Included <input type="checkbox"/> Records Not Available		

Food Allergies/Intolerances: _____

Medications/Supplements: _____

Other pertinent medical information:

Infant Feeding: ☐ Breastfeeding ☐ Formula Feeding ☐ Both

Formula

WIC provides Similac Advance, Sensitive, Total Comfort, and Soy Isomil. At this time, WIC does not cover Similac "Pro" formulas. WIC may only provide other brands of standard infant formulas on a case-by-case basis due to a medical need. If this infant/child requires another Similac formula or a special formula due to a medical condition, the formula must be approved by the PA WIC Program. Use the [Pennsylvania WIC Program Formula Authorization Form](#).

Healthcare Facility Name: _____

Phone: _____

Signature/Title: _____

Date: _____