NEW YORK STATE DEPARTMENT OF HEALTH
DIVISION OF NUTRITION

For WIC Use:	Date Mailed/ Given	Date Rec'd
	Appt Date	WIC ID #

WIC MEDICAL REFERRAL FORM FOR WOMEN

Last Name (Print):_____ First Name: _____

Street:_____ Apt:_____ City: _____ Zip:_____

Phone: ( ) _____ - _____ Date of Birth: _____/_____/_____ On WIC Before: Yes ☐ No ☐

Maiden Name:_____ Language(s) Spoken: _____

I authorize _____(Health Care Provider) to release the information below to the WIC Program, and I authorize the WIC Program to release information about me to this health care provider for the purposes of coordinating my health care. If 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.

YOUR SIGNATURE: _____

Health Care Provider: Please complete this section.

PRENATAL OR POSTPARTUM:

Gravida _____ Para_____ Multi Fetal_____

Pregravid Weight _____pounds **Date:**

EDD _____/_____/_____

Prenatal Care Began _____/_____/_____

☐ Fetal Weight <10th Percentile for Gestational Age

WEIGHT and HEIGHT must be less than 60 days old on the date of the WIC appointment: _____/_____/_____

Date Taken:

Current Weight_____pounds _____/_____/_____

Current Height_____ inches _____/_____/_____

HEMATOLOGY: Date Taken:

Hgb _____gm/dL ***OR*** Hct_____% _____/_____/_____

Blood Lead _____mcg/dL (Optional) _____/_____/_____

- ***Bloodwork must be taken during current pregnancy.***
- ***Bloodwork must be taken after delivery for Breastfeeding/ Postpartum Women.***

BREASTFEEDING/POSTPARTUM: Most Recent Pregnancy

Date of Delivery/(Termination, if any) _____/_____/_____

Total Weight Gained_____pounds Weeks Gestation_____

Current Infant's Birth Weight _____lb _____oz ***OR*** _____kg

SPECIFIC MEDICAL DIAGNOSIS OR NUTRITIONAL/HEALTH RISKS including ICD-9 code

Signature of Health Care Provider

Provider's Name (Please Print):

Title:

Medical Office/Clinic:

Street:

City: Zip:

Phone #: Fax #:

Date: _____/_____/_____

Send Completed Form To:

NEW YORK STATE DEPARTMENT OF HEALTH
DIVISION OF NUTRITION

For WIC Use:

Date Mailed/ Given	Date Rec'd
Appt Date	WIC ID #

WIC MEDICAL REFERRAL FORM FOR INFANTS and CHILDREN

Child's Last Name (Print):_____ Child's First Name: _____

Parent/Caretaker's Name:_____ Street: _____ Apt: _____

City:_____ Zip:_____ On WIC Before: Yes ☐ No ☐ Sex: M ☐ F ☐

Phone: ( ) _____ - _____ Child's DOB: _____/_____/_____ Language(s) Spoken: _____

I authorize _____(Health Care Provider) to release the information below to the WIC Program, and I authorize the WIC Program to release information about my infant/child to this health care provider for the purposes of coordinating his/her health care. If 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.

YOUR SIGNATURE: _____

Health Care Provider: Please complete this section.

BIRTH HISTORY: ❑ SGA (<10th Weight for Gestational Age)

Birth Weight _____lb _____oz ***OR*** _____kg

Birth Length _____in ***OR*** _____cm Weeks Gestation_____

WEIGHT and HEIGHT must be less than 60 days old on the date of the WIC appointment _____/_____/_____ **Date Taken:**

Current Weight _____lb _____oz ***OR*** _____kg _____/_____/_____

Current Height/Length _____in ***OR*** _____cm _____/_____/_____

Measurement Taken: ☐ Standing ☐ Recumbent (< 2 yrs)

HEMATOLOGY: **Date Taken:**

Hgb _____gm/dL ***OR*** Hct_____ _____% ____/____/____

Blood Lead _____ mcg/dL at one year of age ____/____/____

Blood Lead _____ mcg/dL at two years of age ____/____/____

Provide marker IMMUNIZATION dates or attach a copy of record.

	First	Second	Third	Fourth	Fifth
Hep B					
DTP/DTap					
MMR					

SPECIFIC MEDICAL DIAGNOSIS OR NUTRITIONAL/HEALTH RISKS including ICD-9 code

Signature of Health Care Provider

Provider's Name (Please Print):

Title:

Medical Office/Clinic:

Street:

City: Zip:

Phone #: Fax #:

Date: _____/_____/_____

Send Completed Form To:

This institution is an equal opportunity provider.

NEW YORK STATE DEPARTMENT OF HEALTH
Division of Nutrition/WIC Program

Authorization Form

If you would like to authorize another person to represent you at times when you are unable to attend WIC appointments or redeem food instruments, please check either Parent/Spouse/Partner, Representative or Proxy. You are allowed to have up to two persons to represent you but this is not required.

This form does not allow for the release of WIC records.

For Office Use Only

Validation Date: _____

Void Date: _____

Participant's Initials: _____

Participant Name(s)	**Individual WIC ID Numbers**

☐ **Parent/Spouse/Partner**

- has the same rights under the WIC program as the enrolling parent/spouse/partner
- can authorize a Representative or Proxy
- can sign all required forms
- can represent you at your certification appointments
- can represent you at your children's certification appointments
- can represent you and/or your children at nutrition education appointments
- can pick up and redeem your food instruments

☐ **Representative**

- must be someone responsible for the primary care of the participant and able to provide information on the eating habits and medical condition of the participant(s)
- can sign all required forms
- can represent you at your children's certification appointments
- can represent you and/or your children at nutrition education appointments
- can pick up and redeem your food instruments

☐ **Proxy**

- can represent you and/or your children at nutrition education appointments
- can pick up and redeem your food instruments

Signature _____ Date _____

Name (please print) _____

Address _____ Apt. # _____

City _____ State _____ Zip Code _____

Phone # _____

Verification of Correct Information

Initial/Date	Initial/Date
Initial/Date	Initial/Date
Initial/Date	Initial/Date
Initial/Date	Initial/Date

I have instructed the above authorized parent/spouse/partner, representative or proxy on the rules and regulations of the WIC program including proper use of food instruments at redemption locations. I understand that I am liable for improper or fraudulent use of the WIC program by said person.

Signature of Participant/Parent/Guardian (sign only after form is completed) _____ Date _____

DOH-141 (12/09)

DEPARTAMENTO DE SALUD DEL ESTADO DE NUEVA YORK
División de Nutrición/Programa para Mujeres, Bebés y Niños (WIC)

Formulario de autorización

Si desea autorizar a otra persona para que lo represente en las ocasiones en que usted no pueda asistir a las citas del WIC o para retirar cheques para alimentos, marque padre/cónyuge/pareja, representante o apoderado. Puede tener hasta dos personas que lo representen, aunque no es necesario.

Este formulario no permite divulgar los registros de WIC.

Solo para uso de la oficina

Fecha de validación: _____

Fecha de caducidad: _____

Iniciales del participante: _____

Nombre(s) del participante	**Números de identificación en el WIC**

☐ **Padre/cónyuge/pareja**

- tiene los mismos derechos que el padre/cónyuge/pareja participante en el programa WIC
- puede autorizar a un representante o apoderado
- puede firmar todos los formularios necesarios
- puede representarlo en sus citas de certificación
- puede representarlo en las citas de certificación de sus hijos
- puede representarlo a usted y/o a sus hijos en las citas sobre educación de nutrición
- puede recoger y retirar sus cheques para alimentos

☐ **Representante**

- tiene que ser una persona responsable del cuidado principal del participante y que pueda proporcionar información acerca de los hábitos alimenticios y estado de salud del (de los) participante(s)
- puede firmar todos los formularios necesarios
- puede representarlo en las citas de certificación de sus hijos
- puede representarlo a usted y/o a sus hijos en las citas sobre educación de nutrición
- puede recoger y retirar sus cheques para alimentos

☐ **Apoderado**

- puede representarlo a usted y/o a sus hijos en las citas sobre educación de nutrición
- puede recoger y retirar sus cheques para alimentos

Firma _____ Fecha _____

Nombre (escriba con letra de molde) _____

Dirección _____ Apartamento # _____

Ciudad _____ Estado _____ Código postal _____

No. de teléfono _____

Verificación de que la información es correcta (Solo para uso de la oficina)	
Iniciales/Fecha	Iniciales/Fecha
Iniciales/Fecha	Iniciales/Fecha
Iniciales/Fecha	Iniciales/Fecha
Iniciales/Fecha	Iniciales/Fecha

Le he explicado al padre/cónyuge/pareja, representante o apoderado que se autoriza arriba las reglas y reglamentos del programa WIC, incluido el uso adecuado de cheques para alimentos y lugares en que deben retirarse. Comprendo que soy responsable del uso fraudulento o inadecuado del programa de WIC que pueda realizar esa persona.

Firma del participante/cónyuge/guardián (firme solo después de que se llene el formulario) _____ Fecha _____

NEW YORK STATE DEPARTMENT OF HEALTH
Division of Nutrition

Medical Documentation for WIC Formula and Approved WIC Foods for Infants, Children and Women

New York State WIC — Together Growing Stronger Families

WIC Stamp

Instructions: Providers, please complete sections A – C for all WIC participants to request formula and prescribe supplemental foods. (Further instructions on reverse)

A. PATIENT INFORMATION

Patient's Name: _____ **Date of Birth:** ____/____/____

B. FORMULA AND WIC SUPPLEMENTAL FOODS (Provision of formula/food subject to WIC policies and procedures.)

Formula Requested: _____ **Length of Use:** ☐ 1 month ☐ 3 months ☐ 6 months ☐ 12 months ☐ _____ months

Prescribed Amount: _____ **ounces/day**

Special Instructions/Comments: _____

WIC Qualifying Medical Conditions:

☐ Premature Birth	☐ Metabolic Disorders	☐ Failure to Thrive *(Must meet at least one of the criteria on back)*
☐ Low Birth Weight	☐ Immune System Disorders	☐ Severe Food Allergies
☐ GI Disorders	☐ Malabsorption Syndromes	☐ Other (Specify) _____ _____

Note: *These non-specific symptoms/conditions are not acceptable: dermatitis, formula/food intolerance, fussiness, gas, spitting up, constipation, diarrhea, vomiting, colic, or to enhance or manage body weight without an underlying medical condition.*

WIC Supplemental Foods:

☐ Refer to WIC for determination of foods and amounts
☐ No food restrictions
☐ Patient cannot tolerate foods: provide formula only.
☐ Issue modified food package omitting foods checked below.

WIC Category	Check the foods that should **NOT** be issued to the patient.
Infants (6 - 11 mos.)	☐ Infant Cereal ☐ Baby Food Fruits ☐ Baby Food Vegetables
Children (≥ 12 mos.) and Women	☐ Milk ☐ Cheese ☐ Cereal ☐ Whole Grains ☐ Eggs ☐ Juice ☐ Beans ☐ Peanut Butter ☐ Vegetables/Fruit ☐ Canned Fish (if applicable)

C. HEALTH CARE PROVIDER INFORMATION (Contact information may be printed or stamped and must be legible.)

Provider Stamp

Provider's Signature _____ Date _____

Street _____ City, State, Zip Code _____

Provider's Printed Name _____ Telephone Number _____ Fax Number _____

D. RELEASE OF INFORMATION

I authorize the above health care provider and NYS WIC agency staff to disclose/discuss information regarding feeding needs. This permission is good for the length of this certification. I understand that I may cancel this permission at any time by request to my health care provider and WIC. This release is not a condition of WIC eligibility.

Participant/Parent/Caregiver Signature _____ Date _____

Printed Name _____

E. WIC STAFF USE ONLY (WIC staff must complete section in its entirety and note comments/actions) ☐ Consent on file at WIC

Check box next to question if the answer is yes:

☐ Acceptable qualifying condition indicated?
☐ Formula consistent with qualifying condition?
☐ Amount and length appropriate?
☐ Med Doc Foods note written?

☐ Approved ☐ Disapproved ☐ Pending Pending Date & Initial _____

Signature: _____

Printed Name: _____ Date: _____

Comments: _____ WIC ID # _____

NEW YORK STATE DEPARTMENT OF HEALTH
Instructions and Resources for WIC Medical Documentation Form

Federal policy limits the issuance of certain formulas to medically fragile participants with qualifying medical conditions.

Use this form to request exempt formulas, WIC-Eligible Nutritionals, standard formulas for infants unable to tolerate solid foods, and/or supplemental foods for patients with qualifying medical conditions. If you have questions or need additional clarification, please contact the WIC agency where your patient is receiving WIC benefits. A directory of New York WIC agencies can be found at: **http://www.health.ny.gov/prevention/nutrition/wic/local_agencies.htm**.

WIC agency staff will review and fill requests for formulas and supplemental foods according to federal regulations and New York WIC program policies and procedures. WIC may require additional documentation for prescription approval if diagnoses are missing, incomplete, non-specific, or inconsistent with anthropometric data. WIC agency staff may contact you if further clarification is needed.

RENEWAL OF THIS FORM REQUIRED PERIODICALLY

SECTIONS A-C ARE COMPLETED BY HEALTH CARE PROVIDER TO REQUEST WIC FORMULA AND FOODS

A. PATIENT INFORMATION *(Complete for ALL WIC participants.)*

Patient's Name and Date of Birth: Print WIC participant name and date of birth.

B. FORMULA AND WIC SUPPLEMENTAL FOODS *(Complete for ALL WIC participants.)*

WIC Qualifying Medical Conditions: Check (√) beside one or more of the described medical diagnoses or check (√)"Other" and specify the medical diagnosis. (ICD Codes are not required.)

Severe food allergies: *Select for severe or multiple food allergies that require a formula.*

Failure to Thrive (FTT) is a severe condition that the NYS WIC Program takes seriously. The patient must meet at least one of the criteria below that WIC uses to define Failure to Thrive:

- Weight consistently below the 3rd percentile for age;
- Weight less than 80% of ideal weight for height/age;
- Progressive fall-off in weight to below the 3rd percentile; or
- A decrease in expected rate of growth along the child's previously defined growth curve irrespective of its relationship to the 3rd percentile.

WIC measures heights and weights on participants to monitor their growth.Copies of CDC growth charts used by WIC can be found at: **http://www.cdc.gov/growthcharts.**

Formula Requested: Write the prescribed formula name and/or brand. See approved NYS WIC formulas at: **http://www.health.ny.gov/prevention/nutrition/wic/approved_formulas.htm**

Prescribed Amount: Specify amount required in ounces/day. (Ranges allowed. WIC max, ad lib, as tolerated are not acceptable.)

Length of Use: Check (√) the number of months for which the prescription is valid, or enter number of months up to 12.

Special Instructions/Comments: Include details of relevant medical condition, allergies, formula history, etc.

WIC Supplemental Foods: Check one to indicate referral to WIC staff, no food restrictions, formula only, or a modified package. To modify package, check (√) the foods that should NOT be issued.

C. HEALTH CARE PROVIDER INFORMATION *(Complete for ALL WIC participants.)*

Licensed health care provider must sign and date. Contact information may be printed or stamped and must be legible.

SECTION D WILL BE COMPLETED BY PARTICIPANT/PARENT/CAREGIVER – Please sign, date, and print name.

SECTION E WILL BE COMPLETED BY WIC STAFF – Please follow WIC program procedure when completing this form.

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