PEDIATRIC REFERRAL AND SPECIAL DIETARY REQUESTS

WIC AGENCY:

WIC ID:

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☐ **Routine Referral** ***(Complete Section I)*** ☐ **Special Dietary Requests** ***(Complete Sections I and II)***

SECTION I: Complete this section to determine patient eligibility to receive WIC services.

PATIENT NAME *(First)*	*(Last)*			DATE OF BIRTH
CURRENT HEIGHT / LENGTH inches	DATE	CURRENT WEIGHT lb oz	DATE	BIRTH WEIGHT/LENGTH lb oz / inches

HGB tests are required annually if normal; every 6 months if abnormal.

AGE	HGB	or HCT	DATE OF TEST
6 - 13 MO	.	%	
14 - 23 MO	.	%	
24 - 35 MO	.	%	
36 - 47 MO	.	%	

AGE	LEAD RESULTS	DATE OF TEST
12 MO	mcg/dL	
24 MO	mcg/dL	

Immunizations up-to-date for age: ☐ Yes ☐ No ☐ Refused

BREASTFEEDING ASSESSMENT. Doctors recommend fully breastfeeding for six months and continued breastfeeding for the for the first year of life or longer.

☐ Fully breastfeeding per AAP and AAFP recommendations
☐ Combination feeding: Breastmilk and formula
☐ Not breastfeeding; or never Breastfed
☐ Discontinued Breastfeeding; Date:

SOY REQUEST. Check qualifying condition to substitute soy milk and tofu for cow's milk and cheese. Please indicate amounts / days if there are restrictions.

☐ Cow's milk allergy
☐ Cultural beliefs
☐ Lactose intolerance
☐ Other:
☐ Vegan

HEALTH PROFESSIONAL NAME

HEALTH PROFESSIONAL SIGNATURE

PHONE NUMBER

TODAY'S DATE

OFFICE / CLINIC NAME AND LOCATION OR OFFICE STAMP

SECTION II: ONLY complete if there are special dietary needs. Incomplete information may delay issuance of WIC foods.

DIAGNOSIS: Refer patient to health plan for all medically necessary formulas and medical foods. WIC provides these only when NOT AVAILABLE FROM OTHER SOURCES.

☐ Prematurity ☐ Allergy ☐ Other:
☐ Failure to thrive ☐ Dysphagia

MEDICALLY NECESSARY FORMULA/FOOD

DURATION	AMOUNT
months	oz / day

TYPE OF COVERAGE	NAME OF HEALTH PLAN	ACTION TAKEN BY HEALTH PROFESSIONAL	DATE OF ACTION
Medi-Cal Fee-for-Service	Not applicable	Submitted justification to pharmacist	
Medi-Cal Managed Care		Submitted justification to health plan	
Private Insurance		Submitted justification to health plan	

CHECK ALL THAT APPLY:

☐ Approval by payer pending
☐ No insurance, referred to Medi-Cal
☐ Gave formula samples
☐ No insurance options; referred to WIC for payment. WIC requires documentation every 3 months for medically necessary formula

FOOD RESTRICTIONS: Types of food and amounts per month listed below may be issued to this patient unless checked AS NOT APPROPRIATE.

☐ No food restrictions

INFANT (6-11 MONTHS) - Check any foods that should not be issued due to food restrictions.

☐ Infant fruits and vegetables, up to 256 oz
☐ Infant meals, 77.5 oz *(fully breastfed only)*
☐ Infant cereals, 24 oz

CHILD (1-5 YEARS) - Check any foods that should not be issued due to food restrictions.

☐ Cow's milk, 13 qt *in addition to formula*
☐ Whole grains*, 2 lb
☐ Lactose free milk, 13 qt; *in addition to formula*
☐ Dry beans, peas or lentils, 1 lb
☐ Cheese, 1 lb
☐ Breakfast cereals, 36 oz
☐ Eggs, 1 dozen
☐ Vegetables and fruits
☐ Peanut butter, 18 oz
☐ Juice, 128 fl oz

**** Wheat bread / tortilla, corn tortilla, brown rice, barley, bulgur, oatmeal***

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