



# Medical Referral Form for Infants and Children

## Massachusetts WIC Nutrition Program

Child's name: \_\_\_\_\_ DOB: \_\_\_\_\_

**Clinician: Please complete this section - WIC eligibility will depend on this information.**  
 Parent authorization appears on the reverse side of this form.

**Bloodwork required for children > 9 months:**

<b>One blood test required</b>		<b>Date taken:</b>
<b>HGB</b> _____ gm		___ / ___ / ___
or		
<b>HCT</b> _____ %		___ / ___ / ___
Lead _____ mcg		___ / ___ / ___
(optional)		

Weight and height must be less than 60 days old on date of WIC appointment.

Current weight	_____ lb	_____ oz
Current length	_____ in	
Date	___ / ___ / ___	

**First visit only:**

Birth weight	_____ lb	_____ oz
Birth length	_____ in	

Update immunization book or attach copy of record or give dates:

	DTaP	Polio	MMR	Hib	Hep B	VZV	PCV 7
First							
Second							
Third							
Fourth							
Fifth							

**Please note all that apply:**

- Repeated GI disturbances (infant only), mo/yr: \_\_\_ / \_\_\_  
 1. \_\_\_ / \_\_\_      2. \_\_\_ / \_\_\_      3. \_\_\_ / \_\_\_
- Infectious disease, specify: \_\_\_\_\_
- Food allergy or intolerance, specify: \_\_\_\_\_
- Traumatic injury / burns / surgery, mo/yr: \_\_\_ / \_\_\_
- Iron deficiency anemia
- Lead poisoning
- Congenital anomaly or developmental delay impairing feeding / utilization of nutrients
- Failure-to-thrive
- Chronic ear / upper resp. infections within last year, mo/yr:  
 1. \_\_\_ / \_\_\_      2. \_\_\_ / \_\_\_      3. \_\_\_ / \_\_\_
- Mental illness / retardation
- Mother / caretaker with mental illness / retardation
- Mother / caretaker with substance abuse, specify: \_\_\_\_\_
- Chronic nutrition-related medical condition, specify: \_\_\_\_\_
- Other, specify: \_\_\_\_\_
- Please send a copy of the WIC assessment

signature of clinician \_\_\_\_\_  
 clinician's name (please print) \_\_\_\_\_ date \_\_\_ / \_\_\_ / \_\_\_  
 phone \_\_\_\_\_ fax \_\_\_\_\_

health center / hospital \_\_\_\_\_  
 street \_\_\_\_\_  
 city \_\_\_\_\_ zip \_\_\_\_\_

Send completed form to:

**South Berkshire WIC**  
 54 Castle Street  
 Gt. Barrington, MA 01230  
 413-528-0457



# Medical Referral Form for Infants and Children

## Massachusetts WIC Nutrition Program

### Parent/Guardian Authorization: Please complete this section.

Child's name \_\_\_\_\_ (Print Name)      Your name \_\_\_\_\_ (Print Name)  
 Street \_\_\_\_\_ Apt. \_\_\_\_\_      City \_\_\_\_\_ Zip \_\_\_\_\_  
 Phone \_\_\_\_ - \_\_\_\_ - \_\_\_\_      Child's date of birth \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Sex  M  F  
 Child on WIC before?  Yes  No      Language spoken \_\_\_\_\_

I, \_\_\_\_\_ (Print Name) give permission to \_\_\_\_\_ (Doctor, Nurse, Healthcare Provider) to release to WIC information on the MRF, which appears on the other side of this form, for determining the nutritional risk of my child for WIC eligibility.

- I understand that I do not have to give my doctor, nurse, or healthcare provider permission to share information about my child with WIC. If I choose not to give this permission, to receive WIC benefits I will need to give permission directly to WIC to obtain my child's length/height, weight, and bloodwork at the WIC office.
- I understand that I can change my mind and cancel this permission at any time. To do this, I need to write a letter to my provider and send it or bring it where I am now giving permission:

\_\_\_\_\_ (address of Doctor, Nurse, Healthcare Provider)

If the information has already been given out, I understand that it is too late for me to change my mind and cancel the permission.

**Authorized Signature:** \_\_\_\_\_  
**Relationship to Participant:** \_\_\_\_\_  
**Date:** \_\_\_\_ / \_\_\_\_ / \_\_\_\_

**This authorization is valid for 60 days after the date the health information (height/weight) is obtained.**

WIC staff are required to follow federal law to protect WIC participant confidentiality and cannot re-disclose WIC applicant or participant information except with written consent or as required by law.

(see over)

For more WIC forms or for more information, please call WIC at 1-800-WIC-1007.  
 You can also download many of WIC's forms for your patients on line at [www.mass.gov/wic](http://www.mass.gov/wic).

'This institution is an equal opportunity provider.'

For WIC use	initials
Date rec'd _____	_____
Appt. _____	_____
WIC # _____	_____

9/05, #107, Rev. 2003 HIPAA