



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: _____ Current height: _____ For infants under 2 include Head Circumference: _____ Date Measured: _____	Required for children over 9 months Hemoglobin: _____ g/d/l or Hematocrit: _____ % Lead Screening: _____ mcg/dl Date of Blood Test: _____	Required for children under 2 years Gestational Age: _____ Birth Weight: _____ Birth Length: _____ Head Circumference: _____ 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, Spit Up, and Soy Isomil. At this time, WIC does not cover Similac "Pro" formulas. WIC does not provide other brands of standard infant formulas. 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: _____