WIC Referral data form

Use this form to bring in measurements from your health care provider to save time at your next WIC appointment.

Source of data

☐ Health care provider—Provider name: ______________________________

☐ WIC—WIC clinic name: ______________________________

☐ Other: ______________________________

Today's date: ______________________________

Participant name: ______________________________

Date of birth: ______________________________

Date	Length/ Height (in)*	Weight* (lbs)	OFC*	Hgb/ Hct**	Nutrition Assessment

*Valid for 60 days

**Valid for 90 days

Notes:

Health care provider or WIC health professional signature:

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Fax Number: ______________________________ Phone number: ______________________________

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Utah Department of Health & Human Services

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