WIC Referral data form

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

Source of data

☐ Healthcare provider—provider name: ____

☐ WIC—WIC clinic name: ____

☐ Other: ____

Today's date: ____

Parent/Guardian name: ____

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:

Healthcare provider or WIC health professional signature: ____

Fax Number: ______________________________ Phone number: ______________________________