UTAH WIC PROGRAM
WIC REFERRAL 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—Clinic Name: __________________________________________________________________

☐ Other: ____________________________________________________________________________

Today's Date: ________________________________________________________________

Participant Name: _____________________________________________________________

Date of Birth: __________________________________________________________________

<table>
<thead>
<tr>
<th>Date</th>
<th>Length/Height (in)*</th>
<th>Weight* (Lbs)</th>
<th>OFC*</th>
<th>Hgb/ Hct**</th>
<th>Nutrition Assessment</th>
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*Valid for 60 days
**Valid for 90 days

Notes:

Health Care Provider/WIC Health Professional Signature:

______________________________________________________________________________

Fax Number: ______________________ Phone number: ________________________________

Revised 12/2018