State of Illinois
Department of Human Services

# ILLINOIS WIC MEDICAL REFERRAL FORM

This form may be used to provide medical data to the WIC Program. Medical data may also be supplied on a provider signed medical form, letterhead, or other official medical record.

| Participant Name: | Birthdate: |
|---|---|

## Current Measurements (must be within last 60 days)

| | |
|---|---|
| Height/Length: (inches)<br>Date of Measurement: | Weight: (lbs./.oz)<br>Date of Measurement: |
| Hemoglobin or Hematocrit level:<br>Date of lab: | Blood Lead level:<br>Date of lab: |

## Birth Data (complete only if under 2 years old)

| | | |
|---|---|---|
| Birth Length: (inches) | Birth Weight: (lbs./.oz) | Completed weeks gestation: |

## Prenatal Data (complete only if pregnant)

| | |
|---|---|
| Expected Delivery Date: | Monthly Prenatal care began: |
| Current Number of Prenatal Visits: | Pre-Pregnancy Weight: |

## Additional Comments

## Health Care Provider Information

| Health Care Provider's Signature: | Date: |
|---|---|
| Printed Name of Health Care Provider: | |
| Medical Office / Clinic Name: | |
| Address: | |
| Phone: | |

## Please fax, email, or have client return this form to:

This institution is an equal opportunity provider.