MISSOURI DEPARTMENT OF HEALTH AND SENIOR SERVICES
WIC AND NUTRITION SERVICES

WIC REFERRAL

NAME OF PARTICIPANT / APPLICANT: *(Infant, Child or Woman)*	NAME OF PARENT OR GUARDIAN:	REFERRAL SOURCE: ☐ From Physician's Office ☐ From Local WIC Provider ☐ Other_____
ADDRESS: (STREET, CITY, STATE, ZIP CODE)		TELEPHONE NUMBER:

DATE OF BIRTH:	CURRENT WEIGHT:	CURRENT LENGTH / HEIGHT:	INFANTS ONLY	
			BIRTH WEIGHT:	BIRTH LENGTH:

REASONS FOR REFERRAL

(Please check all applicable reasons.)

Infants and Children:

☐ Prematurity_____ Weeks
☐ Small for Gestational Age ☐ Poor Growth
☐ Lead Lab Test Results _____ Date Tested: _____

Women:

☐ Poor Weight Gain
☐ Excessive Weight Gain
☐ Breastfeeding Concerns

Women, Infants & Children:

☐ Hemoglobin/Hematocrit:_____ Date Tested: _____
☐ Oral Health: _____
☐ Other Reasons: *(Be specific)* _____
Comments:

☐ Please waive the physical presence requirement at the WIC appointment due to the participant being medically fragile and/or hospitalized at this time.
Projected Discharge Date: _____ *(Not more than one week from today's date above.)*

Healthcare Provider Only

SIGNATURE OF REFERRING PROVIDER:	PRINT NAME OF REFERRING PROVIDER:	DATE:
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ADDRESS OF REFERRING PROVIDER:	TELEPHONE NUMBER:

Patient/Participant Only

- I understand the organization to which I am being referred to may be covered by its own confidentiality regulations/policies, which may be different from those of the Missouri WIC Program.
- I understand that any formula/food obtained from the WIC Program is for the participant only and cannot be used while the above mentioned infant/child is still in the hospital.

SIGNATURE OF PATIENT, PARTICIPANT, PARENT OR GUARDIAN:

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