



# Pediatric Referral



**CAMINO HEALTH CENTER**  
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WIC ID#: \_\_\_\_\_

**SECTION I: Complete this section to assist the patient with WIC eligibility, WIC services, and appropriate referrals.**

**Whenever a therapeutic formula is prescribed, complete both Sections I and II.**

PATIENT NAME: (First) _____ (Last) _____				DATE OF BIRTH: _____					
CURRENT HEIGHT/LENGTH: (within 60 days) _____ inches	CURRENT WEIGHT: (within 60 days) _____ lbs _____ oz	CURRENT BMI: (within 60 days) BMI percentile: _____ %	MEASUREMENT DATE: _____	BIRTH WEIGHT / LENGTH: _____ lbs _____ oz / _____ inches					
<p><b>HEMOGLOBIN OR HEMATOCRIT TEST</b> is required <u>every 12 months</u> when normal and <u>every 6 months</u> when abnormal.</p> <table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 60%;">Hemoglobin (gm/dl) <u>or</u> Hematocrit (%)</td> <td>Lab Result Date</td> </tr> <tr> <td> </td> <td> </td> </tr> </table>			Hemoglobin (gm/dl) <u>or</u> Hematocrit (%)	Lab Result Date			<p><b>LEAD TEST</b> (recommended at 1–2 years of age): _____ mcg/dL</p> <p><b>IMMUNIZATIONS</b> are up-to-date:  <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not available</p>		
Hemoglobin (gm/dl) <u>or</u> Hematocrit (%)	Lab Result Date								
<p><b>BREASTFEEDING ASSESSMENT</b> (birth to 12 months):</p> <input type="checkbox"/> Fully breastfeeding <input type="checkbox"/> Never breastfed <input type="checkbox"/> Feeding breastmilk & formula <input type="checkbox"/> Discontinued breastfeeding (Date: _____)									

**SECTION II: Complete ALL boxes below when therapeutic formula is prescribed. Incomplete information may delay issuance of WIC foods.**

<p><b>DIAGNOSIS:</b></p> <input type="checkbox"/> Prematurity <input type="checkbox"/> GERD or reflux <input type="checkbox"/> Food allergy: _____ <input type="checkbox"/> Failure to thrive <input type="checkbox"/> Dysphagia <input type="checkbox"/> Other: _____ <p><b>FORMULA / MEDICAL FOOD:</b> _____</p> <p><b>DURATION:</b> _____ months    <b>AMOUNT:</b> _____ oz / day</p> <p>This prescription is: <input type="checkbox"/> New <input type="checkbox"/> Refill</p> <p>NOTE: At 1 year of age, the patient will receive 13 quarts of cow's milk in addition to therapeutic formula unless <i>Do Not Give</i> is checked for cow's milk (see WIC Food Restrictions).</p> <p><b>COMMENTS:</b></p>	<p><b>WIC FOOD RESTRICTIONS:</b> The patient will receive WIC foods in addition to the formula prescribed. Please check all foods listed below that are NOT appropriate for the diagnosis.</p> <table border="1" style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th>Category</th> <th>WIC Foods</th> <th>Do Not Give</th> <th>Restriction / Comment</th> </tr> </thead> <tbody> <tr> <td rowspan="2">Infants (6–11 mo)</td> <td>Baby cereal</td> <td></td> <td></td> </tr> <tr> <td>Baby fruits / vegetables</td> <td></td> <td></td> </tr> <tr> <td>(9–11 mo)</td> <td>Fresh fruits / vegetables</td> <td></td> <td></td> </tr> <tr> <td rowspan="8">Children (1–5 yr)</td> <td>Cow's milk</td> <td></td> <td></td> </tr> <tr> <td>Cheese</td> <td></td> <td></td> </tr> <tr> <td>Eggs</td> <td></td> <td></td> </tr> <tr> <td>Peanut butter</td> <td></td> <td></td> </tr> <tr> <td>Whole grains *</td> <td></td> <td></td> </tr> <tr> <td>Cereal</td> <td></td> <td></td> </tr> <tr> <td>Beans</td> <td></td> <td></td> </tr> <tr> <td>Fruits / vegetables</td> <td></td> <td></td> </tr> <tr> <td>Juice</td> <td></td> <td></td> <td></td> </tr> <tr> <td>Yogurt</td> <td></td> <td></td> <td></td> </tr> </tbody> </table> <p><small>* whole wheat bread, corn/wheat tortilla, brown rice, barley, bulgur, or oatmeal</small></p>	Category	WIC Foods	Do Not Give	Restriction / Comment	Infants (6–11 mo)	Baby cereal			Baby fruits / vegetables			(9–11 mo)	Fresh fruits / vegetables			Children (1–5 yr)	Cow's milk			Cheese			Eggs			Peanut butter			Whole grains *			Cereal			Beans			Fruits / vegetables			Juice				Yogurt			
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**HEALTH COVERAGE: Refer patient to their health plan or Medi-Cal for a medically necessary formula or medical food.**

WIC only provides these products when they are NOT a covered benefit by the patient's health plan or by Medi-Cal.

<p><b>Provide patient's health insurance information:</b></p> <p>Private insurance: _____</p> <p>Medi-Cal managed care: _____</p> <p>Other: _____</p> <p>Regular Medi-Cal (fee-for-service): <input type="checkbox"/> Yes <input type="checkbox"/> No</p>	<p><b>Check action taken:</b></p> <p><input type="checkbox"/> Submitted justification to health plan</p> <p><input type="checkbox"/> Submitted justification to pharmacist</p>	<p><b>If the patient requires a therapeutic formula and does NOT have health insurance, check ALL boxes below that apply:</b></p> <p><input type="checkbox"/> Gave formula samples                    <input type="checkbox"/> Referred to Medi-Cal                    <input type="checkbox"/> Referred to WIC</p> <p><b>QUESTIONS:</b> Call 1-888-942-9675 or 1-800-852-5770.                  Health Professionals: Go to <a href="http://www.wicworks.ca.gov">www.wicworks.ca.gov</a>; click <u>Health Care Professionals</u>; then click <u>WIC contacts for MDs</u>.</p>
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**COMMENTS:**

HEALTH PROFESSIONAL NAME	HEALTH PROFESSIONAL SIGNATURE	MEDICAL OFFICE / CLINIC NAME AND LOCATION OR OFFICE STAMP
PHONE NUMBER	TODAY'S DATE	