New Mexico WIC Program Medical Referral Form

Directions: Please complete the applicable sections and return this form to the closest WIC Clinic. Fax is acceptable.

Required Patient Information			
First Name:	**Last Name:**	**DOB:**	**Sex:** M or F
Phone #: ( )	**Address:**	**City:**	**Zip:**
Medicaid ID Number (if applicable):			
Parent/Caregiver's Name: (Infant's & Children Only)			

Pregnant Women			
Current Height:		Date of Measurement:	(Not older than 60 days)
Current Weight:		Date of Measurement:	(Not older than 60 days)
Hemoglobin Value:	Or Hematocrit Value:	Date of Test:	(Must be for current pregnancy)
Expected Date of Delivery (EDD):		Prepregnancy Weight:	
Date of First Prenatal Visit:			

Breastfeeding & Postpartum Women			
Current Height:		Date of Measurement:	(Not older than 60 days)
Current Weight:		Date of Measurement:	(Not older than 60 days)
Hemoglobin Value:	Or Hematocrit Value:	Date of Test:	(Must be in postpartum period)
Actual Date of Delivery (EDD):		Weight at last Prental Visit:	
Date of First Prenatal Visit:			

Infants and Children Less Than 24 Months of Age			
Birth Weight:	Birth Length:		
Current Weight:		Date of Measurement:	(Not older than 30 days)
Current Length:		Date of Measurement:	(Not older than 30 days)
Hemoglobin Value:	Or Hematocrit Value:	Date of Test:	(Not older than 60 days)

Children 2 to 5 Years of Age			
Current Weight:		Date of Measurement:	(Not older than 60 days)
Current Length:		Date of Measurement:	(Not older than 60 days)
Hemoglobin Value:	Or Hematocrit Value:	Date of Test:	(Not older than 60 days)

Check All That Apply

*Please refer your client to WIC, even if nothing is checked below. This information assists the WIC nutritionist in determining eligibility, developing a nutrition care plan, and providing nutrition counseling. WIC staff may need to contact you or your staff to obtain more detailed medical information prior to providing WIC services.

☐ Medical Condition (Specify):

☐ Food Allergy (Specify):

☐ Recent Major Surgery or Trauma (Specify):

☐ Current or Potential Breastfeeding Complications (Specify):

☐ Other (Specify):

Required Health Care Provider Information

Signature/Stamp of Health Care Provider (MD/DO/PA/CNP):			Date:
Provider Name (Please Print):	Provider NPI Number:	Phone #:	Fax #:

This institution is an equal opportunity provider.