NEW JERSEY WIC HEALTH CARE REFERRAL FOR

☐ **INFANT (Under 1 Year)** ☐ **CHILD (1 to 5 Years)**

(Please attach updated Immunization Record.)

Women, infants and children MUST be present at every WIC certification appointment.
Bring:
- Proof of your family's income
- Proof of where you live
- Proof of ID for every person
- Health care referral form filled out
- Immunization records of infant/child

CALL for an appointment with WIC office checked:
(Healthcare provider: Check WIC office for patient.)

- ☐ Burlington County 609-267-4304
- ☐ Children's Home Society of NJ 609-498-7755
- ☐ East Orange 973-395-8960 (8963)
- ☐ Gloucester County 856-218-4116
- ☐ Jersey City 201-547-6842
- ☐ Newark 973-733-7628
- ☐ North Hudson 201-866-4700
- ☐ NORWESCAP 908-454-1210
- ☐ Ocean County 732-341-9700 X 7520
- ☐ Passaic 973-365-5620
- ☐ Plainfield 908-753-3397
- ☐ Rutgers 973-972-3416
- ☐ St. Joseph 973-754-4575/4730
- ☐ TriCounty/Gateway CAP
  Main Office: 856-451-5600
  Atlantic Office: 609-246-7767
  Camden Office: 856-225-5050
- ☐ Trinitas 908-994-5141
- ☐ VNA 732-471-9301

OR

STATEWIDE
1-800-328-3838 (24 Hrs.)

Name of Child	Birthdate of Child / /
Name of Parent/Guardian	Telephone Number
Address	

ANTHROPOMETRIC AND LABORATORY DATA

- Current height and weight measurements are needed for all infants and children.
- Height and weight measurements must be taken $\leq$30 days prior to WIC appointment.
- At least ONE blood test of Hemoglobin, Hematocrit or Erythrocyte Protoporphyrin (EP) is needed to determine nutritional risk of infants and children OVER 9 MONTHS of age.
- The blood test must be taken $\leq$90 days prior to WIC appointment.

Blood Test Date	Hemoglobin	Hematocrit	EP	Screened for Lead?
/ /	gm/dl	%	µg/dl	☐Yes ☐No µg/dl

Date of Ht./Wt. Measurement	Height or Length	Weight
/ /	inches	lbs. ozs.

COMPLETE THIS SECTION FOR *FIRST TIME* WIC APPLICANTS ONLY

Birth Weight	Birth Length	Premature?	If Yes, Gestational Age at Birth:
lbs. ozs.	inches	☐Yes ☐No	weeks

MEDICAL HISTORY

Check all of the following which apply and give a brief explanation:

	Explanation
☐ Metabolic disorder, congenital anomalies or other medical problem	______________________
☐ Hx of severe diarrhea, steatorrhea, vomiting, malabsorption (3 times during past year or 1 time in past 6 months requiring hospitalization)	______________________
☐ Major surgery (within past 6 months)	______________________
☐ Excessive dental carries/baby bottle tooth decay	______________________
☐ Maternal prenatal conditions (e.g., prenatal anemia, multiple birth, inadequate prenatal weight gain)	______________________
☐ Social or environmental condition which may compromise adequacy of diet	______________________
☐ Vitamin/mineral supplement or medicine prescription	______________________
☐ Other pertinent health or medical data	______________________

AUTHORIZATION RELEASE

I, the undersigned, give permission to my provider to give the WIC Program any required medical information.

Signature of Parent/Guardian	
Insurance Carrier and Member ID Number	
Signature of Physician or Health Professional	Date
Name and Address of Physician or Clinic (Print or Stamp) Telephone Number:	

This institution is an equal opportunity provider.