State of Illinois
Department of Human Services

WIC Referral Form

Clinic Referring: _____ Date: _____

Patient's Name: _____ Name of Clinic: _____

Date of Birth: _____ Name of Physician: _____

Address: _____ Address: _____

City: _____ State: _____ City: _____ State: _____

Phone Number: _____ Zip Code: _____ Phone Number: _____ Zip Code: _____

Health Information
Must not be older than 2 months (60 Days)

This patient is (check one): ☐ Infant ☐ Child ☐ Non-Pregnant Woman ☐ Pregnant Woman

Infants or Children

Height: _____ Weight: _____ Hemoglobin (over 6 months of age): _____

Hematocrit (over 6 months of age): _____ Blood lead (over 6 months of age): _____

If under age 2 Birth Weight _____ If under age 2 Birth Length _____

Head circumference (infants only): _____

Physician Comments/Other Medical Nutritional Issues: _____

Woman

Height: _____ Weight: _____ Hemoglobin: _____

Hematocrit: _____ Blood Pressure: _____

Physician Comments/Other Medical Nutritional Issues: _____

Pregnant Woman

Height: _____ Pre-pregnancy Weight: _____ Expected Delivery Date: _____

Number of Prenatal Visits: _____ Trimester Care Began: _____

Physician Comments/Other Medical Nutritional Issues: _____

Health Care Provider's Signature: _____ Date: _____

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(1) mail: U.S. Department of Agriculture
Office of the Assistant Secretary for Civil Rights
1400 Independence Avenue, SW
Washington, D.C. 20250-9410;

(2) fax: (202) 690-7442; or

(3) email: program.intake@usda.gov

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