UTAH WIC PROGRAM

WIC REFERRAL FORM

Use this form to bring in measurements from your health care provider to save time at your next WIC appointment.

Source of Data

☐ Health Care Provider—Provider Name: _____

☐ WIC—Clinic Name: _____

☐ Other: _____

Today's Date: _____

Participant Name: _____

Date of Birth: _____

Date	Length/Height (in)*	Weight* (Lbs)	OFC*	Hgb/ Hct**	Nutrition Assessment

*Valid for 60 days

**Valid for 90 days

Notes:

Health Care Provider/WIC Health Professional Signature:

_____

Fax Number: _____ _____**Phone number**: _____

Revised 12/2018

UTAH | WOMEN, INFANTS & CHILDREN

UTAH DEPARTMENT OF HEALTH