ARKANSAS WIC REFERRAL FORM FOR INFANTS & CHILDREN

Completed form may be faxed to patient's preferred Local Health Unit (LHU) or provided to patient's guardian. The patient's guardian must contact their preferred LHU to schedule a WIC certification appointment for their infant/child. A list of available LHUs can be found at: www.healthy.arkansas.gov/health-units. This completed form will allow the infant/child to be certified by phone without being present. Form must be completed and signed by a medical professional and be presented at the time of the WIC certification appointment.

Patient Name: ____ **DOB:** ____ /____ /____

Patient Preferred Health Unit / WIC Office: ____

Patient Category (check one): Breastfeeding Infant Non-Breastfeeding Infant Child

Patient Diagnosis or N/A: ________________________ Unit/Room or N/A: _______________

Patient expected date of discharge or N/A: ____

Language or ADA accommodations needed? (check one): YES NO

If yes, please specify: ____

Infant/Child (< 5 years):

Mother's Name: ____________________________________ Mother's DOB: ____ /____ /____

Infants only— WIC referral submitted for the mother as well? (check one): YES NO

Infant/Child Gestational Age at Birth: _____________

Birth Length (to the nearest ¼ in): ____________ Birth Wt (lbs & oz): ____________________

Date of most recent measurements obtained within last 60 days: ____ /____ /____

Length (to the nearest ¼ in): _________ Wt (lbs & oz): _________ Hgb: ______ or HCT: ______

Hemoglobin / Hematocrit is needed on infants >/= to 6 months of chronological age and children of all ages.

Feeding Section:

Is this infant/child receiving any of ***mother's*** breastmilk? (check one): YES NO

Is this infant/child fed via a feeding tube? (check one): YES NO

This infant/child requires the following formula: ____________________________________

Special feeding instructions: ____

Attach completed Medical Documentation Form for Special Formulas & Supplemental Foods (WIC-51) if warranted

Name: ___________________________ Title: MD DO APRN PA RN LPN RD SW

Signature: ______________________________ Date: _____________ Phone: ______________

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