Pennsylvania WIC Healthcare Referral Form

Send completed forms to: pawic@adagiohealth.org

Name: _____ **Date of Birth**: _____

Patient is:	**Ethnicity:**
☐ Pregnant ☐ Breastfeeding ☐ Postpartum	☐ Hispanic or Latino ☐ Not Hispanic or Latino
Race (Check all that apply):	
☐ American Indian/Alaska Native ☐ Asian ☐ Black ☐Native Hawaiian/Pacific Islander ☐ White	

Street Address: _____ **City**: _____

Zip Code: _____ **County**: _____

Phone Number: _____ **E-mail**: _____

Anthropometric Measurements	**Current Bloodwork**	**Birth Information**
	Hemoglobin: _____g/d/l	Due Date: _____
Pre-Pregnancy weight: _____	or	# of Babies Delivered: _____
Current weight: _____	Hematocrit: _____%	
Current height: _____		If the baby is already born
Date Measured: _____	Date of Blood Test: _____	DOB: _____
		Delivery Method: _____

Food Allergies/Intolerances: _____

Medications/Supplements: _____

Medications/Supplements: _____

Other Pertinent Medical Information: _____

_____

Healthcare Facility Name: _____ **Phone**: _____

Signature/Title: _____ **Date**: _____

PA WIC is funded by USDA. This institution is an equal opportunity provider.