STATE OF HAWAII
DEPARTMENT OF HEALTH

WIC SERVICES BRANCH
CERTIFICATION, ELIGIBILITY & COORDINATION

WIC Referral (Fax to 586-8189)

Applicant Name: _____
Last First Middle

Mailing Address: _____
Street Apt No. City Zip Code

Telephone #: _____
Home. Work Pager/Cellular

☐ **Woman**	☐ **Infant**	☐ **Child**
Birthdate: _____ Gravida:_____ Para: _____ Birthdate of Last Child: _____ Prepregnancy Weight: _____ ☐ Pregnant with EDC: _____ ☐ Nursing ☐ Postpartum Delivery Date: _____ Total Pregnancy Wt Gain: _____	Birthdate: _____ Sex: ☐ Male ☐ Female ☐ Stillborn ☐ Full-Term ☐ Premature born at _____ wks gestation	Birthdate: _____ Sex: ☐ Male ☐ Female
Date of Measurements:	Date of Measurements:	Date of Measurements:
Height: Weight:	Length: Weight:	Height Weight:
Date of Lab Values:	Date of Lab Values:	Date of Lab Values:
HCT: HGB	HCT: HGB:	HCT: HGB:

REASON(S) FOR REFERRAL:

☐ Inadequate growth; specify _____

☐ High risk pregnancy; specify _____

☐ High risk infant; specify _____

☐ Anemia

☐ Inadequate diet; specify _____

☐ Other reasons(s); specify _____

DATE: _____ ADDRESS/PHONE STAMP:

PROVIDER SIGNATURE: _____

PRINTED NAME/TITLE: _____

WIC is an equal opportunity provider and employer.