Women, infants and children MUST be present at every WIC certification appointment.
Bring:
- Proof of your family's income
- Proof of where you live
- Proof of ID for every person
- Health care referral form filled out
- Immunization records of infant/child

CALL for an appointment with WIC office checked:
*(Healthcare provider: Check WIC office for patient.)*

- ☐ Atlantic City 609-347-5656
- ☐ Burlington County 609-267-4304
- ☐ Children's Home Society of NJ 609-498-7755
- ☐ East Orange 973-395-8960 (8963)
- ☐ Gloucester County 856-218-9116
- ☐ Jersey City 201-547-6842
- ☐ Newark 973-733-7628
- ☐ North Hudson 201-866-4700
- ☐ NORWESCAP 908-454-1210
- ☐ Ocean County 732-341-9700 X 7520
- ☐ Passaic 973-365-5620
- ☐ Plainfield 908-753-3397
- ☐ Trinitas 908-994-5141
- ☐ St. Joseph 973-754-4575
- ☐ TriCounty/Gateway CAP 856-451-5600
- ☐ UMDNJ 973-972-3416
- ☐ VNA 732-471-9301

OR

STATEWIDE 1-800-328-3838 (24 Hrs.)

# NEW JERSEY WIC HEALTH CARE REFERRAL

**FOR**

☐ **PREGNANT WOMAN**
☐ **BREASTFEEDING WOMAN (Up to 1 Year Postpartum)**
☐ **NON-BREASTFEEDING WOMAN (Up to 6 Months Postpartum)**

| Name | Birthdate / / |
|---|---|
| Address | Telephone Number |

**ANTHROPOMETRIC AND LABORATORY DATA**

- Height and weight measurements must be taken ≤30 days prior to WIC appointment.
- At least ONE blood test of Hemoglobin, Hematocrit or Erythrocyte Protoporphyrin (EP) is needed to determine nutritional risk of all women. The blood test must be taken <90 days prior to WIC appointment..
- PREGNANT WOMEN need blood test which was done during pregnancy.
- POSTPARTUM WOMEN (breastfeeding and non-breastfeeding) need blood test which was done after delivery.

| Blood Test Date / / | Hemoglobin gm/dl | Hematocrit % | EP µg/dl | Lead (if available) | Other |
|---|---|---|---|---|---|
| | | | | | |

| Height inches | Pre-Pregnancy Weight lbs. |
|---|---|
| | |

| | # Wks. Gest. | Measurement Date / / | Weight lbs. | Blood Pressure / mm/Hg |
|---|---|---|---|---|
| **FIRST PRENATAL CHECK-UP** | | | | |
| **MOST RECENT CHECK-UP** | | | | |

**MEDICAL HISTORY**

| Delivery Date / / ☐Estimated ☐Actual | Woman's Weight Just Prior to Delivery lbs. | # Weeks Gestation at Delivery |
|---|---|---|
| | | |

| Date Last Pregnancy Ended / / | No. Previous Pregnancies | No. Previous Live Births |
|---|---|---|
| | | |

Check all of the following which apply and give a brief explanation:

| | Explanation |
|---|---|
| ☐Hx of low birth weight infant(s) (≤5.5 lbs.) | |
| ☐Hx of premature infant(s) (≤37 weeks gestation) | |
| ☐Hx of infant(s) ≥9 lbs at birth | |
| ☐Hx of miscarriage(s)/stillbirth(s)/abortion(s) | |
| ☐Hx of or planned C-section | |
| ☐Multiple pregnancy or recent multiple birth | |
| ☐Medical problems (e.g. Diabetes, Hypertension, Preeclampsia, Eclampsia) | |
| ☐Disability which may compromise adequacy of diet | |
| ☐Social or environmental condition which may compromise adequacy of diet | |
| ☐Substance use (e.g. alcohol, drugs, cigarettes, pica) | |
| ☐Vitamin/mineral supplement or medicine prescription | |
| ☐Special formula prescription and medical reason for its necessity | |
| ☐Other pertinent health/medical data | |

**AUTHORIZATION RELEASE**

*I, the undersigned, give permission to my provider to give the WIC Program any required medical information.*

| Signature of Patient Being Referred | Insurance Carrier and Member ID Number |
|---|---|
| | |

| Signature of Physician or Health Professional | Date |
|---|---|
| | |

Name and Address of Physician or Clinic (Print or Stamp)

Telephone Number: