

### WIC PEDIATRIC REFERRAL

**Health Care Provider:**

Please provide the information requested below for your patient. This information will be used by our Program staff to assess your patient's health status and to provide nutritional counseling. An incomplete referral may delay Program benefits to your patient. A completed referral does not guarantee WIC Program benefits since Program eligibility requirements must be met. **PLEASE NOTE:** WIC provides iron-fortified concentrated liquid and powdered formulas ONLY.

Patient's name (last, first)	WIC identification number	Birth date	Sex <input type="checkbox"/> Male <input type="checkbox"/> Female
Parent/guardian name	Address (street, city, ZIP code)		Phone number

CURRENT	CURRENT (For patients 9 months or older)	BIRTH DATA (For patients under 12 months)	BLOOD LEAD TEST		
Length/height _____ ins. Weight _____ lbs. Measurement Date _____	Hemoglobin _____ gm/dl and/or Hematocrit _____ % Blood Test Date _____	Birthweight _____ lbs. Birthlength _____ ins. <input type="checkbox"/> Small for gestational age <input type="checkbox"/> Preterm (less than 37 wks)		Date	µg/dL
			12-month result		
			24-month result		

IF FORMULA WILL BE NECESSARY AFTER AGE 1 YEAR, REASON AND TYPE OF FORMULA MUST BE INDICATED:

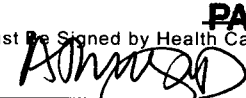
Reason: \_\_\_\_\_  
 Type: \_\_\_\_\_  
 Estimated time needed: \_\_\_\_\_

PLEASE INDICATE ANY MEDICAL CONDITIONS AFFECTING THIS PATIENT:

- Food Allergies   
  Congenital Anomalies   
  Developmental Disabilities   
  Severe Dental Problems   
  Illness, Acute   
  Illness, Chronic  
 Other (specify): \_\_\_\_\_

PLEASE DESCRIBE ANY OF THE CONDITIONS INDICATED ABOVE. INCLUDE DATES WHEN APPLICABLE: \_\_\_\_\_

PLEASE LIST ANY CURRENT MEDICATIONS/SUPPLEMENTS PRESCRIBED: \_\_\_\_\_

LOCAL WIC AGENCY: _____	Name of Physician/Health Care Provider/Group: _____ LPCH (650) 723-8772 Phone Number: _____ IMPORTANT: Must be Signed by Health Care Provider 
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**STANFORD UNIVERSITY  
GENERAL PEDIATRICS  
750 WELCH #325  
PALO ALTO, CA 94304**

**REQUEST FOR SERVICE  
INTER-AGENCY REFERRAL FORM**  
(PRESS HARD)

OPEN \_\_\_\_\_  
CLOSED \_\_\_\_\_


1. NAME To: <b>PRE-TO-THREE</b>		Agency or Dept.	NAME From: <b>STANFORD UNIVERSITY GENERAL PEDIATRICS 750 WELCH #325 PALO ALTO, CA 94304</b>		Agency or I
3. PATIENT'S NAME			4. BIRTHDATE		
5. PATIENT'S ADDRESS			8. ZIP CODE	7. CENSUS TRACT	6. PHONE NUMBER
9. NEAR FRIEND OR RELATIVE (Specify Relationship)			ADDRESS		
10. SOC. SEC. # _____			11. MEDICAL # _____		
12. LANGUAGE: _____					

13. PURPOSE OF REFERRAL -- INCLUDE DIAGNOSIS IF APPLICABLE.

Mother with Newborn Interested in Program

Newborn's Name:

Date of Birth:

DATE \_\_\_\_\_ SIGNATURE  TITLE **WELL BABY NURSERY DIRECTOR**

14. REPORT TO REFERRING SOURCE (INCLUDE EVALUATION, RESPONSE TO CARE, PLAN FOR FUTURE ACTION, ETC.)

RECORD OPENED \_\_\_\_\_  
NOT OPENED \_\_\_\_\_

DATE \_\_\_\_\_ SIGNATURE \_\_\_\_\_ TITLE **030725-0112 NEWBORN Referral Prgm.**



# NEWBORN REFERRAL (NOT AN APPLICATION FOR MEDI-CAL)

(PLEASE USE INK AND PRESS FIRMLY.)



The Newborn Referral Form is used to assist a Medi-Cal eligible mom to report the birth of her child(ren) to Medi-Cal. By completing the information on this form, you help the county confirm the eligibility of the newborn. Mail or fax this form to the county. County information is located on the back of this form. Any changes to the household must be reported to the county, so, turn in this information quickly. The mother may also report the birth by phone to her eligibility worker. If you are acting on behalf of the mother and are not a spouse, relative, or guardian, then your signature and identifying information is required in Section C. If entering through Gateway Program enter the BIC number assigned to the infant (**optional**).

**SECTION A** *The mother's Medi-Cal card can be used during the birth month and the month following for services and billing for the newborn.*

Mother's name (first, MI, last)		Mother's date of birth	BIC or Medi-Cal ID number or SSN
Mailing address (number and street) or location			County
City	State	ZIP code	Telephone number (      )

**SECTION B** *Reminder: A child born to a mother with restricted benefits is eligible for full-scope benefits.*

Newborn name (first, MI, last)	Date of birth (month/day/year)	Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	Optional—Gateway ID number
Newborn 2 name (first, MI, last)	Date of birth (month/day/year)	Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	Optional—Gateway ID number
Newborn 3 name (first, MI, last)	Date of birth (month/day/year)	Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	Optional—Gateway ID number

Where born (hospital name, clinic name, etc.)  
**Lucile Packard Children's Hospital**

Address (number and street, if available) 750 Welch Road	City Palo Alto	State CA	ZIP code 94304
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Will baby and mother live in the same household?       Yes       No  
 If no, has the mother given up rights to the newborn child?       Yes       No  
 If yes, date child(ren) given up:      /      /     

***This form does not start Medi-Cal, CaWORKs, or Food Stamp benefits. If you currently get these benefits, you must contact your eligibility worker to continue getting these benefits.***

*I hereby authorize release of this information to the County Department of Social Services/county welfare department.*

Date of request	Parent/Relative/Guardian (of the infant) signature  <input checked="" type="checkbox"/>
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**SECTION C** *(Fill in this section if form was completed by person other than parent, relative, or guardian.)*

Completed by (PLEASE PRINT)	Title Volunteer with Newborn Referral Program
Medi-Cal ID number (If Medi-Cal provider/hospital/clinic/group, etc.) Lucile Packard Children's Hospital	Telephone number ( 650 ) 723-8772

*I certify to the best of my knowledge that the information above is verified and accurate.*

Signature (person other than parent, relative, or guardian)  <input checked="" type="checkbox"/> <b>STANFORD UNIVERSITY GENERAL PEDIATRICS</b> <i>Amey</i>	Date completed
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For provider information, billing or how to bill for infants, call the EDS Billing Hotline at 1-800-541-5555.

**750 WELCH #325  
PALO ALTO, CA 94304**

Distribution:      White—County      Yellow—Hospital/Clinic/Nurse-Midwife/CAA/AR       Pink—Parent/Relative/Guardian