State of Connecticut WIC Program-DEPARTMENT OF PUBLIC HEALTH
CERTIFICATION/MEDICAL REFERRAL FORM - INFANTS AND CHILDREN

Participant ID #: _____ Family ID #: _____

Child's Name: _____ **Date of Birth (DOB):** ___/____/_____ **Sex:** ☐ **M** ☐ **F**

Parent/Guardian: _____ **Phone:** (____) _____

Address: _____

DATE COLLECTED:	**DATE COLLECTED:**	**FOR INFANTS AND CHILDREN < 2:**
Weight:	**Hemoglobin:**	**Birth Weight:**
Length or Height:	**Hematocrit:**	**Birth Length:**
Body Mass Index (BMI):	**Lead test done?** ☐ **Y** ☐ **N**	**Birth Head Circ. (optional):**
Head Circ. (optional):	**Date collected:** __/__/____ **Result:**	**Immunizations Up-to-date?** ☐ **Y** ☐ **N**
Medications/Medical Problems/Concerns:		

ANTHROPOMETRIC

0-23 months (Based on 2006 WHO Growth Standards)

1a. ☐ Underweight (≤ 2.3rd percentile wt/length)
1b. ☐ At Risk of Underweight (>2.3rd percentile and ≤ 5th wt/length)
2. ☐ High Weight for Length (≥ 97.7th percentile wt/length)
2b. ☐ At Risk of Overweight- Parent with BMI ≥ 30
3a. ☐ Short Stature (≤ 2.3rd percentile length/age)
3b. ☐ At Risk for Short Stature (> 2.3rd & ≤ 5th percentile length/age)
4. ☐ Failure to thrive
5. ☐ Slowed/Faltering Growth Pattern
6. ☐ LBW (birth weight ≤ 5.5 pounds or ≤ 2500 grams)
7. ☐ Pre-term (≤ 36 6/7 weeks gestation); or
☐ Early term (≥ 37 0/7 and ≤ 38 6/7 weeks)
 # wks _____ gestation
8a. ☐ Small for gestational age (based on medical diagnosis)
8b. ☐ Large for gestational age (≥ 9 lbs) (up to 12 months)
9. ☐ Head circumference ≤ 2.3rd percentile (up to 24 months)

2-5 years (Based on 2000 CDC age/gender specific growth charts)

1a. ☐ Underweight (≤ 5th percentile BMI-for-age)
1b. ☐ At Risk of Underweight (>5th and ≤10th percentile BMI-for-age)
2a. ☐ Obese (≥ 95th percentile BMI-for-age)
2b. ☐ Overweight (≥ 85th or <95th percentile BMI-for-age)
2b. ☐ At Risk of Overweight- Parent with BMI ≥ 30
3a. ☐ Short Stature (≤ 5th percentile height/age)
3b. ☐ At Risk for Short Stature (>5th and ≤ 10th percentile ht/age)
4. ☐ Failure to thrive

Weight, length/height measurements must be within 60 days of the WIC certification.

BIOCHEMICAL (1998 CDC Standards)

10. ☐ Anemia **6-23 Mos:** Hgb < 11g/dl, Hct < 32.9%;
2-5 yrs: Hgb < 11.1 g/dl, Hct < 33%)

11. ☐ Elevated blood lead level **9-12 Mos:** ≥ 5ug/dl;
1-5 years: ≥ 3.5ug/dl in last 12 months

CLINICAL/ HEALTH/ MEDICAL

12. ☐ Nutrient deficiency disease. Specify _____
13. ☐ Gastrointestinal disorder. Specify _____
14. ☐ Nutritionally significant genetic or congenital disorder.
Specify_____
15. ☐ Nutrition related infectious disease. ☐ Acute ☐ Chronic
Specify _____
16. ☐ Nutrition related non-infectious chronic disease.
Specify _____
17. ☐ Food allergy. Specify _____
18. ☐ Other nutrition related medical conditions.
Specify _____
19. ☐ Oral health conditions. Specify _____
20. ☐ Fetal Alcohol Spectrum Disorders
21. ☐ Neonatal Abstinence Syndrome (NAS)
22. ☐ Infant/Child of Primary Caregiver with Limited Ability to Make Feeding Decisions or Prepare Food
23. ☐ Breastfeeding complications or potential complications. specify_____
24. ☐ Breastfeeding infant of woman at nutritional risk
☐ non-dietary; ☐ dietary

DIETARY (Document in CT-WIC)

25. ☐ Specify code(s) _____
☐ Improper use of bottle/cup or (pacifier-Child only) ☐ Potentially harmful microorganisms/toxins ☐ Feeding sugar containing fluids

OTHER NUTRITIONAL RISKS

26. ☐ Infant (0-6 months) of a mother enrolled in WIC or of a woman who would have been WIC eligible during pregnancy
27. ☐ Possible regression in nutritional status if removed from the Program ☐ non-dietary; ☐ dietary
28. ☐ Homelessness or migrancy
29. ☐ Entering or moving within the foster care system during the previous 6 months
30. ☐ Other nutritional risks. Specify _____

Health Care Provider Signature and Title: _____ **Date:** _____

Address: _____ **Phone:** _____

Signature/Initials of WIC CPA _____ **WIC Certification Date:** _____ ☐ Mid-cert

Applicant/Participant Authorization/Autorización del solicitante/participante:

I, Yo, _____ give permission to/ doy mi permiso a:
(Print Name/ Nombre en letra de imprenta)

Date/ Fecha ____/____/_____ _____
(Health Care Provider or Organization/ Proveedor de atención de la salud u organización)

Date/ Fecha ____/____/_____ _____
(Health Care Provider or Organization/ Proveedor de atención de la salud u organización)

Date/ Fecha ____/____/_____ _____
(Health Care Provider or Organization/ Proveedor de atención de la salud u organización)

to release my child's health information, listed on the other side of this WIC certification form to the WIC Program, for WIC staff to determine if my child qualifies for the WIC Program and to coordinate WIC nutrition services for my child. I also agree WIC staff may talk with my child's health care provider and/or the organization listed above about any medical/behavioral concerns that may affect my child's overall health in order to better coordinate my child's care.

para divulgar la información de mi hijo —la cual se encuentra en el reverso de este formulario de certificación del Programa WIC, para que el personal del Programa WIC determine si mi hijo es elegible para el WIC y para coordinar los servicios de nutrición que el WIC brindará a mi hijo. También acepto que es posible que el personal del WIC se comunique con el proveedor de atención de la salud de mi hijo o la organización indicada anteriormente sobre toda inquietud médica o del comportamiento que pueda afectar la salud general del mi hijo para coordinar mejor la atención de mi hijo.

- I understand that if my child's well exam is not timed with my WIC certification visit; WIC staff will make efforts to obtain the health information needed to complete the WIC certification visit (e.g. height/length or weight).

- Comprendo que si el examen del niño sano de mi hijo no está coordinado con la visita de certificación del Programa WIC, el personal del WIC se esforzará por obtener la información médica necesaria para completar dicha visita (altura/largo y peso).

- I understand that I can change my mind and cancel this permission at any time. To do this, I need to write a letter to my health care provider or organization listed above and send it or take it to where I am now giving permission. Let WIC staff know if you cancel permission with your provider. ☐ Permission cancelled **Date** ____/____/_____

- Comprendo que puedo cambiar de idea y cancelar esta autorización en cualquier momento. Para hacerlo, debo escribir una carta a mi proveedor de atención de la salud o la organización indicada anteriormente y enviarla o llevarla al lugar donde ahora estoy dando mi permiso. ☐ El permiso cancelado **Fecha** ____/____/_____

Authorized Signature/Firma del representante autorizado: _____

Relationship to Participant/Relación con el participante: _____ **Date/ Fecha** ____/____/_____

This permission is good for one (1) year from the date of the authorized signature above.
Este permiso es válido durante un año a partir de la fecha de la firma del representante autorizado precedente.

If the information has already been given out, I understand it is too late for me to change my mind and cancel the permission.
Si mi información ya ha sido proporcionada, comprendo que es demasiado tarde para que cambie de opinión y cancele el permiso.

WIC staff follows Federal law to protect WIC participant privacy (confidentiality) and cannot re-disclose (share) WIC applicant or participant information except with written consent or as required by law.

El personal del WIC sigue las leyes federales para proteger la privacidad (confidencialidad) de los participantes del WIC y no puede revelar (compartir) la información del solicitante o participante del WIC, a menos que cuente con un consentimiento por escrito o según lo requiera la ley.

☐ **Declined/Rechazado** **Date/ Fecha** ____/____/_____

This institution is an equal opportunity provider. **Esta institución es un proveedor que ofrece igualdad de oportunidades.**

Guidelines for Use

Participant Information and Health Data and Nutrition Risk sections:

- Participant and/or Family ID #: To be completed by WIC Program staff.

- All other **participant information** fields to be completed by WIC staff- most likely a Program Assistant **or** health care provider's (HCP) office staff- including Participant Name, Date of Birth, Sex, Parent's/Guardian's Name, Address, Phone # and Health Insurance Plan.

Participant Health Data fields to be completed by the HCP and/or the WIC Nutrition staff i.e. Competent Professional Authority (CPA). For infants and children: weight, length/height, BMI, hematological data, immunizations and medications/medical conditions. Note: Weight, length/height measurements must be within 60 days of WIC certification appointment.

Hemoglobin or hematocrit results must be within the following timeframes for infant and child participants. Timing of bloodwork is dependent on the initial infant blood test: 9-12 months, 15-18 months, 2 years, 3 years and 4 years. If results are abnormal, a repeat test is required within 6 months as indicated by Federal WIC Regulations, which follow the CDC's *Recommendations to Prevent and Control Iron Deficiency in the United States*. *MMWR* 1998; 47 (No. RR-3) p. 5. HCP or WIC CPA to check all applicable nutrition risk factors including anthropometric, biochemical, clinical/health/medical/ dietary or other based on medical examination or complete nutrition assessment. Specify condition when indicated. Note: If the WIC CPA has questions or concerns regarding data entered by the HCP he/she should follow up as appropriate for clarification.

Health Care Provider Signature and Title is required. This form must be signed by the HCP. By signing this form, the HCP: MD, DO, PA, APRN or RN verifies they have seen and evaluated the patient. In cases where this form is being completed at a time other than certification, e.g., for coordination of health care purposes, a signature is also required for that health care provider as verification. The completed form must include the date and address (location) of practice, clinic, or office.

Shaded Gray area: To be completed by WIC CPA. WIC CPA Signature and WIC Certification date is required to certify the information on the Medical Referral Form has been reviewed and verified. HCP checked Nutrition Risk Criteria should be entered into CT-WIC in the relevant Screens. If the form is being used for a mid-certification, check the appropriate box.

- **If the participant doesn't present with a HCP Completed Medical Referral Form, the WIC CPA doesn't need to complete a paper certification form to process a certification appointment.** Use the Guided Script in CT-WIC to complete the WIC certification process, assess and document risks. Although not required for certification, it is best practice to provide a WIC Certification/Medical Referral Form to participants, Authorized Persons (AP) and/or caretakers to have their HCP complete, to either verify medical conditions or to ensure continuity of care.

Applicant/Participant Authorization Section:
This section must be completed by all applicants and participants, even if the front of the form is filled out prior to the participant visiting the WIC local agency. If applicant or participant declines to allow share anthropometric information with WIC from the health care provider or organization listed, check the box marked, declined. WIC staff must take anthropometric measurements in the WIC office. See WIC 200-13 for more details on this section.