Ohio Department of Health

WIC Interagency Referral and Follow-Up Form

Date	Referred to	FAX

Referring Agency Information

Name		Clinic
Agency		Phone
Address		FAX
City	State	ZIP

Participant Information

Participant name		Birthdate
Parent/Guardian		EDC date
Address		Phone
City	State	ZIP
Email address		

Hgb*	Hct*	Reason for referral and other pertinent medical information
Height*	Weight*	
BMI		

*Indicate date taken if different than the above date.

Consent for Sharing Information

You are not required to consent to sharing any of the above information, but may wish to for the well being of yourself or children. If you decide not to consent, your refusal will not in any way affect the services you receive from WIC. Any information that is shared will be kept confidential.

A signature below indicates you ***give permission*** to share the information included on this form with the "referred to" agency listed above.

Participant, parent, or guardian signature

Response from Physician, Health Clinic or Human Services Agency

Please complete, send one copy to the referring agency address, and retain one copy for your files.

Action taken

Signed	Date

USDA is an equal opportunity provider and employer.

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