NAVAJO NATION WIC NUTRITION PROGRAM
REFERRAL FORM

Participant Name: _____ Chart No.: _____

Participant Address: _____ Birthdate: _____

Height: _____ Weight: _____ Date Measurements Taken: _____

Hematocrit: _____% or Hemoglobin: _____g/dl BMI: _____

Birth Weight (infant/child only): _____Birth Length:_____
(to nearest ounce)

CHECK REASONS FOR REFERRAL UNDER APPROPRIATE COLUMN:

WOMEN (circle one: P PG BF PP)

EDD: _____

____BMI ≤18.5 or ____BMI ≥25

____Anemia

____Close Pregnancies (conception before 16mos)

____Abnormal Weight Gain (low or high, specify below)

____Poor Past Pregnancies (specify below)

____Food Allergies: (specify food(s) below)

____Gestational Diabetes

____Diabetes Mellitus
____Pre-Diabetes

____Lactose Intolerance

____Other Medical/Health Problem(s): specify below

INFANT/CHILDREN (under age 5)

____Underweight for Height/Length

____BMI ≥95%ile for age (2-5 y.o only)

____Anemia ____Diabetes Mellitus

____Premature: born @ _____wks gestation

____Low Birth Weight ____Small for Gest Age

____Failure to Thrive ____Lactose Intolerance

____Elevated Blood Lead level of ____ ug/dl

____Food Allergies: (specify food(s) below)

____Developmental Delay/Sensory/Motor Delay
Interfering with the Ability to Eat

____Low Head Circumference (less than 2 y.o.)

____Other Medical/health Problem(s): specify below

_____

_____

REFERRED BY: (print name)_____ Title:_____

Signature: _____Date:_____

HOSPITAL/CLINIC NAME: _____

ADDRESS:_____PHONE:_____

NNWIC: 04/2015