VIRGIN ISLANDS DEPARTMENT OF HEALTH
WIC PROGRAM
MEDICAL REFERRAL FORM

Last Name:_____ First: _____ DOB:_____ Sex: M___ F___
mm/dd/yy

Mailing Address:_____

Telephone #: home _____ work/cell_____ ID#_____

ANTHROPOMETRIC, MEDICAL AND LABORATORY DATA (To be Filled-In By Medical Provider only):

	Date		**Date**	
Weight_____	_____	HGB_____	_____	**Infants & Children only:**
Height/Length_____	_____	HCT_____	_____	Birth Weight_____
Head Circ._____	_____	MCV_____	_____	Birth Length _____
Blood Pressure _____/_____	_____	Blood Sugar_____	_____	*(If Applicable)*

Pregnant Women:

Pregravid Weight_____ Trimester: _____

Expected Delivery Date_____

Weeks Gestation_____ Date _____

Breastfeeding & Postpartum Women:

Actual Delivery Date_____

Infant's Birth Weight_____

Infant's Birth Length_____

Total Weeks Gestation for Pregnancy_____

List any medical problems, medications or special dietary needs: _____

_____

Name of Medical Provider (print clearly) _____ Telephone #_____

Medical Provider's Signature _____ Date: _____

Medical information is needed for WIC certification. Your physician, medical clinic or health provider may fill-in this form. Bring this form to your WIC Office when you come to apply. In addition to the medical information, you need to bring one document from **each** of the first three categories below to apply for WIC certification (plus #4 for infants & children):

1. Proof of Identity (Picture ID such as Driver's License or Passport; or Birth Certificate)
2. Proof of Residency (such as rent receipt, V.I. Driver's License, electric or phone bill with physical address listed)
3. Proof of Income (such as Food Stamp letter, MAP card, most recent check stub, or employment letter)
4. Immunization Card (for infants and children only)

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Persons with disabilities who require alternative means of communication for program information (e.g. Braille, large print, audiotape, American Sign Language, etc.), should contact the Agency (State or local) where they applied for benefits. Individuals who are deaf, hard of hearing or have speech disabilities may contact USDA through the Federal Relay Service at (800) 877-8339. Additionally, program information may be made available in languages other than English.

To file a program complaint of discrimination, complete the USDA Program Discrimination Complaint Form, (AD-3027) found online at: http://www.ascr.usda.gov/complaint_filing_cust.html, and at any USDA office, or write a letter addressed to USDA and provide in the letter all of the information requested in the form. To request a copy of the complaint form, call (866) 632-9992. Submit your completed form or letter to USDA by:

(1) Mail: U.S. Department of Agriculture
Office of the Assistant Secretary for Civil Rights
1400 Independence Avenue, SW
Washington, D.C. 20250-9410;

(2) Fax: (202) 690-7442; or

(3) E-mail: program.intake@usda.gov.

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