

**Kentucky WIC Referral Form**  
**Referrals for Breastfeeding Support and WIC Services**

Patient's First & Last Name: \_\_\_\_\_ Date of Birth (MM/DD/YY): \_\_\_\_\_  
(For Infants/Children) Parent/Caregiver's First and Last Name: \_\_\_\_\_

Clinic/Hospital/Medical Office Name: _____	To Locate your County Health Department, please visit <a href="https://chfs.ky.gov/agencies/dph/dafm/Pages/lhd.aspx">https://chfs.ky.gov/agencies/dph/dafm/Pages/lhd.aspx</a> (select Listing of LHDs) OR call 1-877-597-0367
Street Address: _____	
City: _____	
Zip Code: _____	
Phone Number: _____	
Fax Number: _____	

**Infants/Children Referral Data: (Complete Applicable Information)**

Date: \_\_\_\_\_ Length/Ht: \_\_\_\_\_ Wt: \_\_\_\_\_ lbs. \_\_\_\_\_ oz. Date: \_\_\_\_\_ Hgb/Hct: \_\_\_\_\_  
(Valid within 60 days of measurement) (Valid within 90 days of measurement)

Birth weight: \_\_\_\_\_ lbs. \_\_\_\_\_ oz. Birth Length: \_\_\_\_\_ in. If premature, weeks gestation at birth: \_\_\_\_\_

Breastfeeding?:  Yes  No

Referral data provided by: (signature) \_\_\_\_\_ Date: \_\_\_\_\_

**Women Referral Data: (Complete Applicable Information)**

Date: \_\_\_\_\_ Length/Ht: \_\_\_\_\_ Wt: \_\_\_\_\_ lbs. \_\_\_\_\_ oz. Date: \_\_\_\_\_ Hgb/Hct: \_\_\_\_\_  
(Valid within 60 days of measurement) (Valid within 90 days of measurement)

EDC: \_\_\_\_\_ Last Wt. Prior to Pregnancy: \_\_\_\_\_ lbs. Multiple Gestation?:  Yes  No

Delivery Date: \_\_\_\_\_ Last Wt. Prior to Delivery: \_\_\_\_\_ lbs. Breastfeeding?:  Yes  No

If Currently Breastfeeding:  Exclusively  Partially  Unknown

Breastfeeding follow up needed?:  Yes  No  Mother/baby separation

Latch-on issues  Milk supply concerns  Other: \_\_\_\_\_

Additional Comments/Details \_\_\_\_\_

Referral data provided by: (signature) \_\_\_\_\_ Date: \_\_\_\_\_

**Instructions & Resources for Use of This Form:**

- This form is intended for use as...
- A medical data referral form for infants, children and women for the Kentucky WIC Program
  - A breastfeeding support referral form for the Kentucky WIC Program
  - A proof of identification for newborn infants

**\*Participant must be physically present for WIC certification appointments.**  
Contact the WIC Program for information regarding any exemptions to this requirement such as medically fragile.

To prescribe a special formula or medical food for an infant, child, or woman please refer to:  
Certificate for Medical Necessity for Formula and WIC Food Exceptions Form (WIC-200, WIC-300, WIC-400)  
<https://chfs.ky.gov/agencies/dph/dmch/nsb/Documents/ClinicalNutritionandBreastfeedingSupport.pdf> , See page 71



**We appreciate your cooperation and partnership in serving the Kentucky WIC population.**  
**This institution is an equal opportunity provider.**