

# Minnesota WIC Medical Data Form

Health Care Providers: Use this form to provide medical data to the WIC Program. Medical data may also be provided on a signed medical prescription form, signed letterhead, or other official medical record. Electronic option: scan the QR code to send the medical data.



 **Patient Demographics**

**Name: ­­­­­­­­­­­­­­­­­­­** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date of Birth: ­­­­­­­­­­­­­­­­­­**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 **Medical Information**

## Date of Anthropometric Measurements: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Weight:**

 lbs. oz. **or** kg. gm.

## Length/Height:

 ft. in. **or** cm. mm. (Recumbent? Y/N)

## Date of Bloodwork Measurements: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Hgb:** g/dl **Hct:** %

**Health Professional Information**

**Health Professional’s Name:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Health Professional’s Signature:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Today’s Date:** \_\_\_\_\_\_\_\_\_\_ **Provider’s Phone Number:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Clinic Name:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*This institution is an equal opportunity provider.*

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