



**NEW JERSEY WIC HEALTH CARE REFERRAL**

**FOR**

**INFANT (Under 1 Year)**  
**CHILD (1 to 5 Years)**

**WIC Appointment Date:**

**CALL or Email WIC office** checked to make an appointment (Healthcare provider: Check WIC office for patient.)

Burlington County  
609-267-4304  
WIC@co.burlington.nj.us

Children's Home Society of Mercer NJ  
609-498-7755  
wicnutritionist@chsofnj.org

East Orange  
973-395-8963(8963)  
wic@eastorange-nj.gov

Gloucester County  
856-218-4116  
gcwic@co.gloucester.nj.us

Jersey City  
201-547-6842  
wichelp@jcnj.org

City of Newark  
973-733-7628  
NewarkWIC@ci.newark.nj.us

North Hudson Community Action  
201-866-4700  
wic2@nhcac.org

NORWESCAP  
908-454-1210  
wic@norwescap.org

Ocean County  
732-370-0122  
WIC@ochd.org

Passaic City  
973-365-5620  
passaicwic@cityofpassaicnj.gov

Plainfield  
908-753-3397  
wic@plainfieldnj.gov

Rutgers Medical School  
973-972-3416  
rutgerswic@njms.rutgers.edu

St Joseph's Hospital  
973-754-4575/4730  
wic@sjhmc.org

Tri-County/Gateway CAP  
856-451-5600  
tricity\_wic@gatewaycap.org

Trinitas  
908-994-5141  
WIC@rwjbh.org

VNACJ  
732-471-9301  
wic@vnahg.org

Name of Child	Birthdate of Child / /
Name of Parent/Guardian	Telephone Number

Address

**ANTHROPOMETRIC AND LABORATORY DATA**

- Current height and weight measurements are needed for all infants and children.
- Height and weight measurements must be **within 60 days** of WIC appointment.
- At least ONE blood test of Hemoglobin, Hematocrit or Erythrocyte Protoporphyrin (EP) is needed to determine nutritional risk of infants and children OVER 9 MONTHS of age.
- The blood test must be taken **within 60 days** of WIC appointment.

Blood Test Date / /	Hemoglobin gm/dl	Hematocrit %	EP µg/dl	Screened for Lead? <input type="checkbox"/> Yes <input type="checkbox"/> No µg/dl
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Date of Ht./Wt. Measurement / /	Height or Length inches	Weight lbs. ozs.
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**COMPLETE THIS SECTION FOR FIRST TIME WIC APPLICANTS ONLY**

Birth Weight lbs. ozs.	Birth Length inches	Premature? <input type="checkbox"/> Yes <input type="checkbox"/> No	If Yes, Gestational Age at Birth: weeks
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**MEDICAL HISTORY**

Check all which apply and give a brief explanation:

Metabolic disorder, congenital anomalies or other medical problem that interferes with nutrition	_____
Hx of food allergies, severe diarrhea, steatorrhea, vomiting, malabsorption	_____
Major surgery (within past 6 months)	_____
Excessive dental carries/baby caries	_____
Other pertinent health or medical data	_____

WIC Certification appointments may be in person or remote, check with your WIC office. Bring or upload your documents (Proofs) to NJWIC Portal or email your WIC Office.

**Visit the NJ WIC Portal:** <https://wicnj.gov/participantportal>

**Documents to bring or upload:**  
**Proof of your family's income, Proof of where you live, Proof of ID** for every person applying for WIC Benefits, and **Health care referral** form filled out ( this form).

**AUTHORIZATION RELEASE**

*I, the undersigned, give permission to my provider to give the WIC Program any required medical information.*

Signature of Parent/Guardian

Participating in Medicaid? Yes or No If yes, CCN #:

Signature of Physician or Health Professional	Date
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Name and Address of Physician or Clinic (Print or Stamp)

Telephone Number: