Minnesota Department of Health Exhibit 5-Y

# Minnesota WIC Program Request for Medical Follow-up

**To:** *(Name, title, and name or address of organization to whom referral is made)*

Click or tap here to enter text.

**From:** *(Local Agency Name, address, phone #, fax #)*

Click or tap here to enter text.

Patient’s Name Click or tap here to enter name. DOB Click or tap to enter a date.

Parent/Guardian’s Name Click or tap here to enter name EDC if applicable Click or tap to enter a date.

Address Click or tap here to enter address

Mobile Phone Click to enter number. Home Phone Click to enter number Other Click to enter text.

Family is aware of referral. Release of information has been obtained. Date obtained Click to enter date.

**Reason for Referral:** Click or tap here to enter text.

Click or tap here to enter text. Click or tap here to enter signature Click to enter a date.

Name & Title of Person Making Referral Signature Date

**Medical Provider: Please complete this section and return to the WIC agency listed above. Thank you.**

**Findings:**

**Recommended Follow-up:**

Name & Credential of Medical Provider Signature Date