 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