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)*

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

Patient's Name DOB

Parent/Guardian's Name EDC if applicable

Address

Mobile Phone Home Phone Other

☐ Family is aware of referral. Release of information has been obtained. Date obtained

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Reason for Referral:

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