WIC ANTHROPOMETRIC AND LABORATORY INFORMATION REQUEST

Michigan Department of Health and Human Services

Medical Provider: Please complete the information below based on most recent visit.

Client 1 Full Name	Date of Birth	Parent/Guardian Name	
Length/Height (in/cm)		Date Taken	
Weight (lb/kg)		Date Taken	
Head Circumference (in/cm) (<24 months)		Date Taken	
Hemoglobin or Hematocrit		Date Taken	
Lead Test/Method		Date Taken	
☐ Infants Only (if checked, complete)			
Birth Length	Birth Weight	Birth Head Circumference	Weeks' Gestation

Client 2 Full Name	Date of Birth	Parent/Guardian Name	
Length/Height (in/cm)		Date Taken	
Weight (lb/kg)		Date Taken	
Head Circumference (in/cm) (<24 months)		Date Taken	
Hemoglobin or Hematocrit		Date Taken	
Lead Test/Method		Date Taken	
☐ Infants Only (if checked, complete)			
Birth Length	Birth Weight	Birth Head Circumference	Weeks' Gestation

Doctor/Clinic Office Name	Office Phone Number

WIC Agency Name		
Fax Number	Phone Number	Email (encrypt if sending by email)
Comments		

The Michigan Department of Health and Human Services will not exclude from participation in, deny benefits of, or discriminate against any individual or group because of race, sex, religion, age, national origin, color, height, weight, marital status, gender identification or expression, sexual orientation, partisan considerations, or a disability or genetic information that is unrelated to the person's eligibility.

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