FORM 113 11/2020

Health Assessment

RETURN TO WIC AGENCY:

Idaho Falls Fax 208-533-3258

PATIENT NAME: (First) (Last)			DATE OF BIRTH:
MEASUREMENTS			
HEIGHT/LENGTH: ________________________inches	WEIGHT: _______________lbs______________oz	BMI: _______________________%	MEASUREMENT DATE: __________________________
BLOODWORK			

HEMOGLOBIN (gm/dl)	Lab Result Date

LEAD TEST?	Lab Result (optional)
❒ Yes ❒ No	__________mcg/dl Date__________________

HEALTH CARE PROVIDER INFORMATION		
NAME:	SIGNATURE:	OFFICE NAME/LOCATION/PHONE:
COMMENTS:		TODAY'S DATE:

WIC is an equal opportunity provider.

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