FORM 113 11/2020

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COMMENTS:



Health Assessment

RETURN TO WIC AGENCY:

RETURN TO WIC AGENCY:

TODAY'S DATE:

Idaho Falls Fax 208-533-3258

PATIENT NAME: (First)	(Last)	DATE OF BIRTH:										
HEIGHT/LENGTH:	MEAS WEIGHT:	UREMENTS	BMI:		MEASUREMENT DATE:							
inches	lbs	OZ		%								
BLOODWORK												
HEMOGLOBIN (gm/dl)	Lab Result Date	LEAD TEST? Yes No		Lab Result (optional)mcg/dl Date								
HEALTH CARE PROVIDER INFORMATION												
NAME:	SIGNATURE:				OFFICE NAME/LOCATION/PHONE:							
COMMENTS:	1			TODAY'S DATE:								

WIC is an equal opportunity provider.

USC IDAHO	Hea	alth Asses	SS	sme	nt	Idaho Falls Fax	208-533-3258				
PATIENT NAME: (Fi	rst)	(Last)		DATE OF BIRTH:							
MEASUREMENTS											
HEIGHT/LENGTH:		WEIGHT:			BMI:		MEASUREMENT DATE:				
	inches	lbs		OZ		%					
			BLC	ODWORK							
HEMOGLOBIN (gm	/dl)	Lab Result Date		LEA Yes	D TEST?	mcg/	Result (optional) dl Date				
NAME:	•	HEALTH CAR SIGNATURE:	RE PR	ROVIDER INFO	ORMATION	OFFICE NAME/L	OCATION/PHONE:				