Florida Department of Health WIC Program Bloodwork Request Form Client's Name: Date of Birth:	Florida Department of Health WIC Program Florida HEALTH Client's Name: Date of Birth:
WIC ID Number (optional):	WIC ID Number (optional):
The following information is needed to complete the client's WIC certification:	The following information is needed to complete the client's WIC certification:
Hemoglobin Level: Date Taken: OR Hematocrit Level: Date Taken:	Hemoglobin Level: Date Taken:OR Hematocrit Level: Date Taken:
Signature/Title of Health Professional Date of Signature	Signature/Title of Health Professional Date of Signature
Office Stamp:	Office Stamp:
DH 3181, 1/16 This institution is an equal opportunity provider.	DH 3181, 1/16 This institution is an equal opportunity provider.
Florida Department of Health WIC Program	Florida Department of Health WIC Program
Florida HEALTH Bloodwork Request Form Client's Name: Date of Birth:	Florida HEALTH Bloodwork Request Form Client's Name: Date of Birth:
WIC ID Number (optional):	WIC ID Number (optional):
The following information is needed to complete the client's WIC certification:	The following information is needed to complete the client's WIC certification:
Hemoglobin Level: Date Taken:	Hemoglobin Level: Date Taken:

Date of Signature

This institution is an equal opportunity provider.

Hematocrit Level:_____ Date Taken:_____

OR

Office Stamp:

DH 3181, 1/16

Signature/Title of Health Professional

This institution is an equal opportunity provider.

Date of Signature

Hematocrit Level:_____ Date Taken:_____

Office Stamp:

OR

Signature/Title of Health Professional