

Request for WIC Therapeutic Products and Supplemental Foods

All requests are subject to WIC approval and provision based on policy and procedure.

Patient Information (required)

Patient's Full Name: _____ DOB: _____
 Date of Measurements: _____ Length/Height: _____ Weight: _____
 If Premature, Birth Weight: _____ Weeks Gestation: _____

Formula Requested (required)

DO NOT FILL OUT FOR 19 CALORIE FORMULA

<p>For intolerance to Similac Advance or Similac Isomil, choose one alternate 19 calorie WIC formula below:</p> <p>Similac Sensitive (lactose sensitivity or colic) Similac for Spit-Up (excess spit-up or GER) Similac Total Comfort (digestive issues or colic)</p> <p>Formula Amount: _____ oz. per day <i>Maximum allowed may be provided unless a lesser amount is indicated.</i></p> <p>Requested Length of Issuance: _____ month(s) <i>Formula will be issued up to 12 months of age unless otherwise indicated.</i></p>	<p>Therapeutic Formulas: If none of the formulas in the left box are appropriate for this patient, select a qualifying condition and fill out the following:</p> <p>Name of Formula: _____ Formula Amount: _____ oz. per day Requested Length of Issuance: _____ month(s) <i>Formula can only be issued up to 6 months per request.</i></p> <p>Clinical Findings: _____ Formula History: _____</p>
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Qualifying Condition/Diagnosis (required; please check all that apply)

DO NOT CHECK FOR 19 CALORIE FORMULA

Cardiovascular condition	Malabsorption syndromes	Tube feeding
Prematurity/LBW	FTT	GI impairment
Oral motor feeding issues/aversions	Low maternal weight gain/weight loss	Neurological condition
Developmental delays (sensory & motor)	Food allergies (cow's milk, soy or intact protein)/FPIES	
Other medical condition*: _____		

***The following symptoms are not qualifying conditions and will not be accepted: colic, constipation, spitting up or gas.**

WIC Supplemental Foods (optional)

Unless indicated below, all supplemental foods will be provided. The RD/Nutritionist can also determine foods if left blank.

Infants 6 months of age and older: Formula only, no foods (due to inability or delay in consuming solids) Omit Infant Cereal Omit Baby Foods	Women & Children 12 months of age and older: Formula only, no foods Omit — check foods to omit from food package Milk Yogurt Eggs Juice Peanut Butter Cheese Cereal Whole Grains Beans Fruits and Vegetables Provide baby foods instead	ISSUE: Whole Milk 2% Milk (Must have medical reason)
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Please fax this completed form to the WIC clinic or have your patient return it to their WIC clinic

Health Care Provider Information (required)

(MD, DO, PA-C, NP) Signature/Stamp: _____ Date: _____
 Provider's Name (please print): _____ Facility Name: _____
 Phone: _____ Fax: _____

For WIC use only

WIC Clinic: _____