WIC Clinic: ________
Phone:(_____)________
Fax:(_____)__________

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: ____________________

Recommended (not required): Date of Measurements:__________ Length/Height:________ Weight:________

Therapeutic Formula Requested (all sections required)

Name of Formula: ______________________________ Requested Length of Issuance: ____month(s)

This formula can only be issued up to 6 months.

Check one:

Infant - Amount per Day
Maximum ounces allowed by WIC for Fully Formula Fed Infant
0-3 mos - 26 fluid oz/day
4-5 mos - 29 fluid oz/day
6-12 mos - 20 fluid oz/day

Other amount: __________ oz/day
(writing in max will not be accepted)

Check one:

Child/Woman - Amount per Day
8ozs (1can/day)
16ozs (2 cans/day)
24ozs (3 cans/day)

Other amount: __________ oz/day
*Amount per day cannot exceed 30 ounces (maximum issuance allowed by USDA).

Qualifying Condition/Diagnosis (required; please check all that apply)

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 CPA 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 package
Milk
Yogurt
Eggs
Juice
Cheese
Cereal
Whole Grains
Peanut Butter
Fruits and Vegetables
Provide baby foods instead
Beans

ISSUE:
Whole Milk
2% Milk
HCP must provide medical reason:

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: ____

 This institution is an equal opportunity provider.