



**TENNESSEE DEPARTMENT OF HEALTH
REQUEST FOR WIC THERAPEUTIC PRODUCTS AND SUPPLEMENTAL FOODS
MUST BE COMPLETED BY HEALTHCARE PROVIDER**

Patient's Name: _____ Date of Birth: _____

Formula Requested: _____ Dilution Strength (if >standard for product) _____

Amount per 24 hours: maximum allowed (approx. 26 oz/day) or _____ day Tube Fed: Y N
Requested length of issuance: 1mo 2mo 3mo 4mo 5mo 6mo

Most Recent Date of Measures: _____ Weight: _____ Height/Length: _____

Nutrition Related **WIC Qualifying Condition:** _____

If food allergy must specify the confirmed allergic disorder:

- Food protein induced enterocolitis Eosinophilic gastroenteritis Gastrointestinal anaphylaxis
- Food protein induced proctocolitis Eosinophilic esophagitis Atopic disease
- Food protein enteropathy, celiac Acute or chronic urticaria & angiodema

Clinical Findings, Laboratory Results, Diagnostic Evidence of Need: _____

Supplemental WIC foods listed below will be issued in addition to the formula /nutritional product requested. Please indicate any food restrictions or provisions for the patient.			
Infants (6-11 months)	Children & Women		
DO NOT GIVE: Infant Cereal Infant Vegetables/Fruits	DO NOT GIVE: Milk Cheese Juice Eggs	Peanut Butter Dried Beans/Peas Whole Grain Products Soy Beverage or Tofu	Vegetables/Fruits Cereal Canned Fish (Breastfeeding Women Only)
	DO PROVIDE: Higher Fat Milk: 2% Whole Pureed (Infant Food) Vegetables/Fruits		

Prescribing Health Care Provider (HCP):

Name: _____

Address: _____

Contact Phone: _____ Fax: _____

Signature (including credentials) _____ Date of Request: _____

REQUEST IS SUBJECT TO TN WIC APPROVAL AND PROVISION BASED ON PROGRAM REGULATION AND POLICY

WIC Use Only _____