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)

For intolerance to Similac Advance or Similac Isomil, choose one alternate 19 calorie WIC formula below:

- ❑ Similac Sensitive (lactose sensitivity or colic)
- ❑ Similac for Spit-Up (excess spit-up or GER)
- ❑ Similac Total Comfort (digestive issues or colic)

Formula Amount: ______________ oz. per day
Maximum allowed may be provided unless a lesser amount is indicated.

Requested Length of Issuance: ______________ month(s)
Formula will be issued up to 12 months of age unless otherwise indicated.

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:

Name of Formula: ______________

Formula Amount: ______________ oz. per day
Maximum allowed may be provided unless a lesser amount is indicated.

Clinical Findings: ______________

Requested Length of Issuance: ______________ month(s)
Formula can only be issued up to 6 months per request.

Formula History: ______________

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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 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

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: ______________