Tennessee Health Department
WIC Medical Request for Formula/Foods

Patient's Name: _____ **Date of Birth:** _____

REQUEST FOR ALTERNATE CONTRACT FORMULA

Similac Advance (milk-based) and Similac Soy Isomil are provided by parent/caregiver request. An alternate Similac formula **(19 calories per ounce)** requires a written request from the Health Care Provider. Check below to request an alternate formula:

☐ For lactose sensitivity and/or colic give Similac Sensitive (reduced lactose)

☐ For digestive issues and/or colic give Similac Total Comfort (partially hydrolyzed protein)

☐ For gastroesophageal reflux give Similac For Spit-Up (added rice starch, reduced lactose)

Formula amount per day: _____(Maximum provided, approx. 26 oz/day, unless reduced amount is indicated)

Number Months of Issuance: _____ (Will be issued up to 12 months of age unless otherwise indicated)

WIC SUPPLEMENTAL FOODS

All appropriate WIC foods will be issued with prescribed formula unless checked DO NOT GIVE.

Infants (6-11 months) **DO NOT GIVE**	Children (born prematurely) **DO NOT GIVE** the WIC Foods checked below:		
☐ Infant Cereal ☐ Infant Food Vegetables & Fruits	☐ Cheese ☐ Cereal ☐ Juice	☐ Eggs ☐ Vegetables/Fruits	☐ Whole Grain Products ☐ Dried Beans or Peas

HEALTH CARE PROVIDER (HCP) INFORMATION (Signature and all information below required to process request):
By my signature below I attest that the patient needs the formula that is requested. I also acknowledge that these formulas are 19 calories per ounce, which is less than the standard 20 calories per ounce.

Signature of HCP: _____ Date: _____

Provider's Name (Please Print): _____

Contact Phone: (_____) _____ Fax: (_____) _____

Address: _____