WIC Clinic: _____
Phone:(____)_____
Fax:(____)_____

TN Department of Health

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 program amounts shown for Fully Formula Fed Infants
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 (1 can/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)

This documentation needs to be updated every six months.

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; maximum program formula amount 29 fluid oz/day)

☐ 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: _____