

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: \_\_\_\_\_  
 Date of Measurements: \_\_\_\_\_ Length/Height: \_\_\_\_\_ Weight: \_\_\_\_\_  
 If Premature, Birth Weight: \_\_\_\_\_ Weeks Gestation: \_\_\_\_\_

**Formula Requested (required)**

**DO NOT FILL OUT FOR 19 CALORIE FORMULA**

<p><b>For intolerance to Similac Advance or Similac Isomil, choose one alternate 19 calorie WIC formula below:</b></p> <p>Similac Sensitive (lactose sensitivity or colic)          Similac for Spit-Up (excess spit-up or GER)          Similac Total Comfort (digestive issues or colic)</p> <p>Formula Amount: _____ oz. per day  <i>Maximum allowed may be provided unless a lesser amount is indicated.</i></p> <p>Requested Length of Issuance: _____ month(s)  <i>Formula will be issued up to 12 months of age unless otherwise indicated.</i></p>	<p><b>Therapeutic Formulas:</b>          If none of the formulas in the left box are appropriate for this patient, select a qualifying condition and fill out the following:</p> <p>Name of Formula: _____          Formula Amount: _____ oz. per day          Requested Length of Issuance: _____ month(s)  <i>Formula can only be issued up to 6 months per request.</i></p> <p>Clinical Findings: _____          Formula History: _____</p>
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**Qualifying Condition/Diagnosis (required; please check all that apply)**

**DO NOT CHECK FOR 19 CALORIE FORMULA**

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.

<p>Infants 6 months of age and older:</p> <p>Formula only, no foods (due to inability or delay in consuming solids)</p> <p>Omit Infant Cereal</p> <p>Omit Baby Foods</p>	<p>Women &amp; Children 12 months of age and older:</p> <p>Formula only, no foods</p> <p>Omit — check foods to omit from food package</p> <p>Milk    Yogurt    Eggs    Juice    Peanut Butter    Cheese    Cereal</p> <p>Whole Grains    Beans    Fruits and Vegetables    Provide baby foods instead</p>	<p><b>ISSUE:</b></p> <p>Whole Milk                  2% Milk</p> <p><b>(Must have medical reason)</b></p>
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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: \_\_\_\_\_