ITO WIC Special Formula or Medical Food Request Form

All sections must be complete for consideration to approve special formula or medical food for a woman, infant or child.

_____ _____ _____/_____

Participant Name | Date of Birth | If premature: weeks gestation & birth weight

Specific medical condition(s) must be included to justify request (formula intolerance, lactose intolerance, milk protein allergy, soy protein allergy, weight loss, managing body weight, diarrhea, constipation, vomiting, rash, colic or colic symptoms are not valid medical reasons)

_____

ICD code(s) – must be included to justify request

_____ _____ _____

Weight | Length/height | Date taken (within 30 days of request)

_____ Amount: [ ] _____ per day **OR** [ ] Maximum allowed by Federal Guidelines

Formula or Medical Food Requested | Requested Duration: [ ] 1 month [ ] 2 months [ ] 3 months

_____

Previous Formula(s) used, duration and results

If special formula is approved, retrial of a standard WIC contract formula must occur with results documented before a subsequent special formula request is considered.

Additional Supplemental Foods to include:

If this section left blank, all supplemental foods will be provided at the maximum allowable amount per category and age.

[ ] None; supplemental food is contraindicated at this time. Omit all supplemental foods and provide formula/medical food only.

[ ] Healthcare Provider will select appropriate foods below at the maximum allowable amount unless otherwise indicated.

Infants (6-11 months)	[ ]Infant Cereal	[ ]Infant Fruits/Vegetables	[ ]Infant Meats(fully BF only)	[ ]Fresh Fruits/Vegetables(9-11 mo.)	
Women	[ ]Milk	[ ]Soymilk	[ ]Cheese	[ ]Yogurt	[ ]Eggs
and	[ ]Tofu	[ ]Beans	[ ]Peanut Butter	[ ]Juice	[ ]Whole Grains
Children (1-5 years)	[ ]Infant Cereal	[ ]Breakfast Cereal		[ ]Canned Fish (fully breastfeeding women only)	
	[ ]Infant Fruits & Vegetables			[ ]Fresh or Frozen Fruits & Vegetables	

Healthcare Provider Signature (MD, DO, PA, ARNP, CNS, CNM):_____

Provider's Name (please print): _____ Date: _____

Name of Medical Office/Clinic: _____

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

Please fax the completed form to the WIC clinic or have your patient return the document to their WIC clinic.

WIC Staff Use Only

_____ Approved_____ Denied_____

WIC Registered Dietitian Signature | Date | For issuance months: _____

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