WISCONSIN WIC REQUEST FOR MEDICAL FORMULA/FOOD: Infants and Children

All requests are subject to WIC approval and provisions based on program policy and procedures.
Please fax or email this completed form to the WIC clinic or have your patient return it to their WIC clinic.

Patient's Full Name ______________________ Birthdate (MM/DD/YY) ________

Parent/Caregiver's First and Last Name ______________________

Clinical Data	Weight: _____ Date: _____	Length/Height: _____ Date: _____	Gestational Age at Birth in weeks: _____	Birth Weight: _____	Birth Length: _____
	Hgb: _____ g/dL or Hct: _____% Date: _____		Lead: _____ mcg/dL Date: _____		

I. Qualifying Medical Condition *required to complete*

Symptoms such as constipation, diarrhea, spitting up, milk/formula intolerance, fussiness, gas, or picky eating are **not** considered acceptable medical diagnoses and will not be approved by WIC for issuance of a medical formula. WIC **cannot** provide formula to enhance nutrient intake or manage body weight without underlying medical conditions.

- ☐ Premature birth
- ☐ Low birth weight
- ☐ Failure to thrive due to _____
- ☐ Severe food allergies (specify) _____
- ☐ Immune system disorder (specify) _____
- ☐ Metabolic disorder/inborn errors of metabolism (specify) _____
- ☐ Malabsorption syndromes (specify) _____
- ☐ Gastrointestinal disorder _____
- ☐ Gastroesophageal Reflux Disease
- ☐ Other medical condition that impairs nutrition status (specify) _____

II. Requested Medical Formula *required to complete*

A. Infant/Child Formula Type:

- ☐ Enfamil NeuroPro EnfaCare
- ☐ Enfamil Pregestimil
- ☐ EleCare Infant DHA/ARA
- ☐ EleCare Jr.
- ☐ Gerber Extensive HA
- ☐ Neocate Infant DHA/ARA
- ☐ Neocate Elecare Jr.
- ☐ Neocate Jr.
- ☐ Neocate Splash
- ☐ Nutramigen
- ☐ Nutramigen w/Enflora LGG
- ☐ Similac Advance
- ☐ Similac Alimentum
- ☐ Similac NeoSure
- ☐ Similac PM 60/40
- ☐ Similac Sensitive
- ☐ Similac Soy Isomil
- ☐ Similac Spit Up
- ☐ Similac Total Comfort
- ☐ PediaSure Grow & Gain
- ☐ PediaSure Grow & Gain 1.5 cal
- ☐ PediSure Peptide 1.0 cal

B. Requested Amount: _____ ounces/day or ☐ Max amount WIC provides for infants

WIC's monthly max amounts may not meet patient's full needs, see: www.dhs.wisconsin.gov/wic/professionals.htm.

C. Intended length of use: ☐ 1 month ☐ 3 months ☐ 6 months ☐ _____ months *(not to exceed 12 months)*

III. Special Instructions

_____

IV. Contraindicated Supplemental Foods

Starting at 6 months of age, WIC provides supplemental foods. If the patient requires food restrictions please complete the following (the WIC RD will assess if left unchecked):

- ☐ ≥ 6 months cannot tolerate solid food: provide formula only
- ☐ ≥ 12 months cannot tolerate solid foods: provide infant fruits and vegetables
- ☐ ≥ 24 months, whole milk, only in combination with medical formula and medical diagnosis
- ☐ OMIT the following food (s) based on medical condition:

Infants (6-11 months): ☐ Infant cereal ☐ Infant f/v ☐ Infant meats ☐ Fresh f/v (9-11 months)

Children (≥12 months): ☐ Dairy foods ☐ Whole grains ☐ Cereal ☐ Juice ☐ Peanut butter ☐ Beans ☐ Eggs ☐ Fruits and vegetables

V. Health Care Provider Information *required*

SIGNATURE – Health Care Provider (MD, DO, PA, ARNP) | Date Signed

Printed Name of Health Care Provider:

Medical Office/Clinic:

Telephone Number: Fax Number:

Local WIC Project Name, Phone Number, Fax Number, Email

WIC USE ONLY ☐ Approved ☐ Not Approved

By: ______________________

Date: ______________________

Date new request needed: ______________________