Medical Documentation Form for Special Needs Food Packages

Client Name: _____

Date of Birth: _____ WIC Client ID: _____

Please fully complete every section (1-7) to avoid delays in issuance. Please choose WIC routine formulas whenever possible, as noted by '*'

1. Current Formula Request:

- ☐ Similac Advance (20 Cal/oz.)*
- ☐ Similac Sensitive*
- ☐ Similac for Spit-up*
- ☐ Similac Total Comfort*
- ☐ Similac Soy Isomil*
- ☐ Alimentum
- ☐ Nutramigen
- ☐ Similac Expert Care Neosure (Powder and RTF)
- ☐ Pediasure (must meet WIC criteria for issuance)
- ☐ **Other:** _____

2. Amount of Formula Requested Per Day: _____
(If no amount written, amount defaults toWIC Maximum)

☐ Oral ☐ Tube Feeding

3. Form of Formula:

☐ **Powder** ☐ **Concentrate** ☐ **Ready-to-feed**

Note: Powder form given to premature clients unless otherwise specified.

4. Diagnosis for Similac Advance (20 Cal/oz.), Similac Sensitive (19 Cal/oz.), Similac for Spit-up (19 Cal/oz.), Similac Soy Isomil, and Similac Total Comfort (19 Cal/oz.):

☐ Formula Intolerance ☐ Food allergy ☐ Inappropriate growth patterns ☐ Other: _____

Diagnosis for Special Formula or Medical Food:

☐ Prematurity ☐ GERD or reflux ☐ Dysphagia ☐ Failure to thrive
☐ Severe food allergy _____ ☐ Other: _____

Note: Must be a specific medical diagnosis.

5. WIC Foods:

☐ Default to WIC Registered Dietitian (RD)/Qualified Nutritionist to choose appropriate WIC foods
OR Check any foods listed below that are not appropriate for this patient

Category	WIC Foods	Do Not Give
Infants (6-11 mo.) or Special Needs Women/Children	**Infant cereal**	☐
	Jarred-fruits/vegetables	☐
Children (1-5 yr.) and Women	**Cow's milk**	☐
	Cheese	☐
	Yogurt	☐
	Eggs	☐
	Peanut butter	☐
	Whole grains**	☐
	Cereal	☐
	Beans	☐
	Vegetables/fruits	☐
	Juice	☐
	Soy milk	☐
	Tofu	☐
Exclusively Nursing Only:		
Women	**Canned Fish**	☐
Infants (6-11 mo.)	**Infant Jarred Meats**	☐

Note:
Children 12-23 months old are typically given whole milk. Anyone 2 and older is given 1%/fat free milk. If another milk type is needed please include in comment section.

Comments:

***Grains include the options of whole wheat bread, brown rice.*

6. Length of Time Requested: ☐ Up to first birthday **OR** # months: _____

7. Print Provider Name: _____ **Title (Circle): M.D., D.O., P.A., N.P., N.M.D. Date:** _____

Healthcare Provider Signature: _____ **Phone Number:** _____