WOMEN, INFANTS AND CHILDREN (WIC)

Medical Documentation Form
For Special Formulas & Supplemental Foods

WIC use only:

Date received: ____________________

CPA name: ____________________

Clinic name: ____________________

Household ID: ____________________

State/WIC ID:

All requests are subject to approval by a WIC Registered Dietitian based on program policies. Please complete sections A-D; numbers 1-15. A WIC staff member may contact you to request additional information. Questions? Contact the Arkansas WIC Program Nutrition Section: 501-661-2508

A. PATIENT INFORMATION

1. Name:
2. DOB:
3. Weight:
4. Length/Height:
5. Date of measure:

B. SPECIALIZED FORMULA NEEDS

6. Length of issuance: ☐ 3 mo ☐ 6 mo ☐ 12 mo ☐ Other: ☐ D/C prescribed formula
7. Prescribed amount: ☐ Max allowed ☐ 24 oz/day ☐ 16 oz/day ☐ 8 oz/day ☐ Other:
8. Formula(s) to provide & special instructions:

Prematurity:
- ☐ EnfaCare powder
- ☐ EnfaCare RTU
- ☐ NeoSure powder
- ☐ NeoSure RTU

Extensively Hydrolyzed:
- ☐ Extensive HA powder
- ☐ Nutramigen powder
- ☐ Nutramigen concentrate
- ☐ Nutramigen RTU
- ☐ Alimentum powder
- ☐ Alimentum RTU
- ☐ Pregestimil powder

Amino Acid Based:
- ☐ Alfamino Infant powder
- ☐ Alfamino Junior powder

Oral Supplements/Tube Feedings:
- ☐ Boost Kid Essentials 1.0 RTU
- ☐ Nutren Junior 1.0 RTU
- ☐ Nutren Junior 1.0 with Fiber RTU
- ☐ Peptamen Jr. 1.0 RTU
- ☐ Neocate Splash RTU

Specialized:
- ☐ PM 60/40 powder
- ☐ Portagen powder
- ☐ Fortini RTU

Metabolic (specify below):
- ☐ ____________________
  ____

Special instructions (specify below):

9. Medical diagnosis or qualifying condition:

Check all that apply:
- ☐ Prematurity: _________ weeks
- ☐ Cow's milk protein allergy
- ☐ Soy protein allergy
- ☐ Sensitivity to cow's milk protein
- ☐ Multiple food allergies
- ☐ Known/suspected corn allergy
- ☐ Eosinophilic GI disorder
- ☐ Chronic diarrhea
- ☐ GI bleeds/bloody stool
- ☐ Severe malnutrition
- ☐ Short bowel syndrome
- ☐ Malabsorptive condition
- ☐ Pancreatic insufficiency
- ☐ Chylothorax
- ☐ Bile acid deficiency
- ☐ Biliary Atresia
- ☐ Liver disease
- ☐ Lymphatic abnormality
- ☐ Chronic kidney disease
- ☐ Congenital heart defect
- ☐ Cystic fibrosis
- ☐ Hyperphenylalaninemia
- ☐ PKU
- ☐ Cancer
- ☐ Requires tube feedings
- ☐ Oral motor feeding disorder
- ☐ Failure to thrive
- ☐ Other (specify below):

Reason for RTU/concentrate:
- ☐ Unsafe/limited water supply
- ☐ Improper formula preparation
- ☐ Prematurity
- ☐ Tube feedings

C. SUPPLEMENTAL FOOD RESTRICTIONS & REQUESTS

10. ☐ Provide default/standard food package for age without restrictions **OR** ☐ Make the following adjustments to the patient's WIC food package:

Infants:
- ☐ Omit all infant foods until: ____________________
- ☐ Give pureed fruits & vegetables in place of fresh fruits & vegs (applies to infants 9 months of age & older)

Children & Women:
- Omit: ☐ milk ☐ cheese ☐ eggs ☐ grains ☐ beans ☐ peanut butter ☐ fruits & vegs
- ☐ Give soy milk to child <2 years
- ☐ Give infant foods in place of child food package until: ____________________
- ☐ Give whole milk to child >2 years (FTT diagnosis required) ☐ Give 2% milk (children & women)

Reason for restriction/request: ☐ Preterm ☐ Food Allergy ☐ Tube Fed ☐ Oral Motor Feeding Disorder ☐ FTT ☐ Other:

D. MEDICAL PROVIDER INFORMATION

11. Provider's name: ____________________
12. Credential/Title: ☐ MD ☐ DO ☐ APRN ☐ PA
13. Provider's signature:
14. Phone:
15. Date:

WIC use only: Approved? ☐ Yes ☐ No Renewal? ☐ Yes ☐ No Start date: ____________________

Name of approving RD: ____________________ Expiration date: ____________________

Approved formula name: ____________________ Amount: ____________________