

State of Connecticut WIC Program-Department of Public Health
MEDICAL DOCUMENTATION FOR WIC FORMULA AND APPROVED WIC FOODS
WOMEN

Patient's Name: _____ **Date of Birth (DOB):** ___/___/___

Formula requested: _____

Prescribed ounces per day* (unless ad lib): _____ Powder Concentrate Other _____

**WIC is a supplemental nutrition program and may not provide the total amount of formula or food prescribed. Prescription is subject to WIC approval and provision is based on Program policy and procedure. No prescription is valid for more than six months.*

Indicate the special/exempt formula requested instructions for preparation and intended length of use. It is WIC's policy to re-evaluate the participant's continued need for the formula on a periodic basis.

Instructions for preparation: _____

Caloric density (e.g. 20cal/oz; 24 cal/oz; 30 cal/oz) _____ Length of use: 1 mo 3 mos 6 mos

REQUIRED: Select qualifying medical condition(s)/ICD code(s)

Select from the list of most common nutrition related ICD medical diagnoses determine and document one or more of the patient's serious qualifying medical condition(s) for which WIC prescriptions may be written.

<input type="checkbox"/> 693.1 Allergy, Food <input type="checkbox"/> 343.9 Cerebral Palsy <input type="checkbox"/> 250.01 Diabetes Mellitus Type I <input type="checkbox"/> 271.1 Galactosemia <input type="checkbox"/> 279.3 Immunodeficiency <input type="checkbox"/> 646.8 Low Maternal Weight Gain <input type="checkbox"/> 271.3 Lactose Intolerance	<input type="checkbox"/> 783.2 Maternal Weight Loss During Pregnancy <input type="checkbox"/> 651 Multifetal Gestation <input type="checkbox"/> 358.9 Neuromuscular Disorder <input type="checkbox"/> 270.1 Phenylketonuria (PKU) <input type="checkbox"/> _____ Other diagnosis with ICD-9 code Specify _____
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Patient must have a diagnosis and not symptoms.

Medical Documentation for Whole Milk:

Does this patient require whole milk based on a qualifying condition? Yes No

Women who are receiving formula for a qualifying medical condition and also receive milk are provided fat reduced milk. Whole milk can be provided if based on a documented qualifying medical condition that warrants the use of a high calorie special formula or supplement.

WIC Supplemental Foods Available Check foods that are **not allowed** based on medical diagnosis

The patient will receive supplemental foods from the WIC Program, appropriate to her participant category in addition to the formula indicated. Please check any supplemental foods contraindicated by the patient's medical diagnosis. If there are only restrictions to amounts of supplemental foods provided due to medical diagnosis, check box and explain in the space provided. Prescription renewal is required periodically, based on medical condition.

- | | | |
|--|--|--|
| <input type="checkbox"/> Milk | <input type="checkbox"/> Whole wheat bread /whole grains | <input type="checkbox"/> Peanut Butter |
| <input type="checkbox"/> Soy Milk/Tofu | <input type="checkbox"/> Breakfast cereal | <input type="checkbox"/> Vegetables and fruits |
| <input type="checkbox"/> Cheese | <input type="checkbox"/> Whole grain pasta | <input type="checkbox"/> All foods contraindicated |
| <input type="checkbox"/> Yogurt | <input type="checkbox"/> Legumes (beans/peas) | <input type="checkbox"/> Restrictions in amounts: Explain: _____ |
| <input type="checkbox"/> Juice | <input type="checkbox"/> Eggs | |

REQUIRED: Refer to WIC Nutrition Professional to identify appropriate types and amounts of WIC Supplemental Foods.* Yes No

***By checking this box you authorize the WIC Nutrition Professional to make future decisions about WIC Supplemental Foods.**

HEALTH CARE PROVIDER SIGNATURE: _____	Date: _____
<small>(MD, APRN or PA)</small>	
Printed Name (Health Care Provider): _____	Phone: _____
Provider Stamp or Address: _____	Fax: _____

A Health Care Provider's **original signature** is required. Print or stamp your name, medical office, phone number and address. By signing this form, you are verifying you have seen and evaluated the patient's nutrition and feeding problem(s) and symptoms determining, she has a serious medical condition. Give the completed form to the patient to take to their local WIC program or fax to the clinic serving the patient.

For more information or additional copies of this form please visit our website: www.ct.gov/dph/wic, then click on "For Medical Providers" tab in the left navigation bar.

Date received: ___/___/___	HCP contacted? <input type="checkbox"/> Yes <input type="checkbox"/> No	
WIC Nutritionist Signature: _____	Date: ___/___/___	