

Wisconsin WIC Referral/Request for Medical Formula/Food: Infants and Children

All requests are subject to WIC approval based on program policy and procedures. Please fax/email this completed form to the WIC clinic.

Section I: Complete this section to assist with WIC eligibility and services. Complete both sections I and II when a medical formula/food is requested.

Patient's full name: _____			Birthdate (MM/DD/YY): _____		
Parent/caregiver's first and last name: _____			Phone number: _____		
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: _____	

Infant/child receiving: ☐ parent human milk ☐ donor human milk ☐ fortified human milk
☐ no human milk ☐ Support needed for human milk feeding and/or expression Notes: _____

Section II: Complete all boxes to request a medical formula/food. Incomplete information may delay WIC approval. See page two for detailed instructions.

A. Qualifying medical condition *required*

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.

- | | |
|---|--|
| <input type="checkbox"/> Premature birth | <input type="checkbox"/> Metabolic disorder/inborn errors of metabolism (specify) _____ |
| <input type="checkbox"/> Low birth weight | <input type="checkbox"/> Malabsorption syndromes (specify) _____ |
| <input type="checkbox"/> Failure to thrive due to _____ | <input type="checkbox"/> Gastrointestinal disorder _____ |
| <input type="checkbox"/> Severe food allergies (specify) _____ | <input type="checkbox"/> Gastroesophageal reflux disease |
| <input type="checkbox"/> Immune system disorder (specify) _____ | <input type="checkbox"/> Other medical condition that impairs nutrition status (specify) _____ |

B. Requested medical formula *required*

All Wisconsin WIC approved formulas are listed here. Write-ins are not allowed.

- | | | |
|--|--|--|
| <input type="checkbox"/> Enfamil AR | <input type="checkbox"/> Neocate Jr. | <input type="checkbox"/> Similac NeoSure |
| <input type="checkbox"/> Enfamil NeuroPro EnfaCare | <input type="checkbox"/> Neocate Syneo Jr. | <input type="checkbox"/> Similac PM 60/40 |
| <input type="checkbox"/> EleCare Infant DHA/ARA | <input type="checkbox"/> Neocate Splash | <input type="checkbox"/> Similac Sensitive |
| <input type="checkbox"/> EleCare Jr. | <input type="checkbox"/> Nutramigen (liquid) | <input type="checkbox"/> Similac Soy Isomil |
| <input type="checkbox"/> Extensive HA | <input type="checkbox"/> Nutramigen w/Probiotic LGG (powder) | <input type="checkbox"/> Similac Total Comfort |
| <input type="checkbox"/> Kate Farms Pediatric Standard 1.2 | <input type="checkbox"/> PurAmino | <input type="checkbox"/> PediaSure Grow & Gain |
| <input type="checkbox"/> Neocate Infant DHA/ARA | <input type="checkbox"/> Similac Advance | <input type="checkbox"/> PediaSure 1.5 cal |
| <input type="checkbox"/> Neocate Syneo Infant | <input type="checkbox"/> Similac Alimentum | <input type="checkbox"/> PediaSure Peptide 1.0 cal |

Requested amount: _____ ounces/day or ☐ Max amount WIC provides (*for infants only*)

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

Special instructions (optional): _____

Continued on next page.

C. Supplemental food restrictions *required*

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):

- ☐ No food restrictions currently
- ☐ ≥ 6 months cannot tolerate solid food: provide human milk and/or formula only
- ☐ ≥ 12 months cannot tolerate solid foods:
 - ☐ provide infant fruits and vegetables in lieu of fresh, frozen, and canned fruits and vegetables
 - ☐ provide infant cereal in lieu of breakfast cereal
- ☐ ≥ 24 months, provide whole milk (only in combination with medical formula and medical diagnosis)
- ☐ Omit the following food(s) based on medical condition: _____

D. Health care provider information *required***Signature** – Health care provider (MD, DO, PA, NP)

Date signed

Printed name of health care provider:

Medical office/clinic:

Phone number:

Fax number:

Local WIC agency name, phone number, fax number, email

Sauk County WIC, 505 Broadway, Baraboo, WI 53913
608-355-4320
Fax 608-355-4329
wic@co.sauk.wi.us

Nondiscrimination statement available at:

www.dhs.wisconsin.gov/wic**WIC USE ONLY**☐ Approved ☐ Not approved

By: _____

Date: _____

Date new request needed: _____

Instructions

Use this form to make a referral to WIC and/or request medical formulas/foods for infant and child patients with qualifying medical conditions. If you have questions or need additional clarification, please contact the WIC agency where your patient is receiving WIC benefits. A directory of Wisconsin WIC agencies can be found at: www.dhs.wisconsin.gov/WIC/local-projects.htm

A WIC Registered Dietitian Nutritionist (RDN) reviews and fills requests for formulas and supplemental foods according to federal regulations and Wisconsin WIC program policies and procedures. WIC may require additional documentation for request approval if diagnoses are missing, incomplete, non-specific, or inconsistent with anthropometric data. A WIC RDN may contact you if further clarification is needed.

Renewal of this form is required periodically

Section I:

Patient information: Patient first and last name, patient date of birth, name and phone number of parent/caregiver.

Clinical data: Enter the patient's most recent measurements to decrease repetition at the WIC appointment and to support formula/food requests.

Human milk:

- Select one of the human milk feeding options next to "infant/child receiving".
- Check the box if the patient needs support with human milk feeding and/or expression from WIC. Local WIC agency staff are trained to support human milk feeding. Add notes as needed.

Section II:

A. Qualifying medical condition: Select one or more of the described medical diagnoses or "other medical condition that impairs nutrition status" and specify diagnoses. ICD codes are not required.

1. Medical formulas/foods cannot be provided by WIC solely for the purpose of enhancing nutrient intake or managing body weight without an underlying qualifying condition.
2. Pediatric beverages cannot be issued solely for the following: a child refuses to take a multivitamin; a child has picky eating; a child is underweight, but is not diagnosed as having failure to thrive, and the diet can be managed using regular foods; a child is assessed to be at risk for or is overweight; or a child is assessed to be at an average Body Mass Index.

B. Requested medical formula: Select the requested formula. All Wisconsin WIC approved formulas are listed on the form. For additional formula information, go to www.dhs.wisconsin.gov/wic/professionals.htm.

1. Requested amount:

- a. Infants: Infant typically receive the maximum amount WIC provides. If less, specify amount in ounces/day. Consider human milk intake. WIC provides the appropriate amount of formula to support the patient's human milk feeding goals. WIC cannot provide more than the maximum amounts set by USDA.
- b. Children: Specify amount required in ounces/day. Ranges are allowed. WIC max, ad lib, and as tolerated are not acceptable. Consider human milk, milk/milk alternatives, and other food intake.

2. **Intended length of use:** Check or write in the number of months, not to exceed 12 months.

3. **Special instruction:** As needed, include instructions on feeding plan such as human milk feeding, combination feeding, mixing/fortification, human milk and formula history.

C. Supplemental food restrictions: WIC provides supplemental foods starting at 6 months of age. The WIC RDN will assess if left blank and contact the clinic to clarify the feeding plan as needed.

D. Health care provider information: Licensed health care provider must sign and date. This can include physician, physician assistant, and advanced practice certified nurse prescriber such as a nurse practitioner and certified nurse midwives who have obtained certification to prescribe. Contact information may be printed or stamped and must be legible.

We appreciate your cooperation and partnership in serving the Wisconsin WIC population.