TN Department of Health

Request for WIC Therapeutic Products and Supplemental Foods

All requests are subject to WIC approval and provision based on policy and procedure.

Patient Information (required)

Patient's Full Name: _____ DOB: _____

Date of Measurements: _____ Length/Height: _____ Weight: _____

If Premature, Birth Weight: _____ Weeks Gestation: _____

Formula Requested (required) **DO NOT FILL OUT FOR 19 CALORIE FORMULA**

For intolerance to Similac Advance or Similac Isomil, choose one alternate 19 calorie WIC formula below:

- ☐ Similac Sensitive (lactose sensitivity or colic)
- ☐ Similac for Spit-Up (excess spit-up or GER)
- ☐ Similac Total Comfort (digestive issues or colic)

Formula Amount: _____ oz. per day

Maximum allowed may be provided unless a lesser amount is indicated.

Requested Length of Issuance: _____ month(s)

Formula will be issued up to 12 months of age unless otherwise indicated.

Therapeutic Formulas:
If none of the formulas in the left box are appropriate for this patient, select a qualifying condition and fill out the following:

Name of Formula: _____

Formula Amount: _____ oz. per day

Requested Length of Issuance: _____ month(s)

Formula can only be issued up to 6 months per request.

Clinical Findings: _____

Formula History: _____

Qualifying Condition/Diagnosis (required; please check all that apply) **DO NOT CHECK FOR 19 CALORIE FORMULA**

- ☐ Cardiovascular condition
- ☐ Malabsorption syndromes
- ☐ Tube feeding
- ☐ Prematurity/LBW
- ☐ FTT
- ☐ GI impairment
- ☐ Oral motor feeding issues/aversions
- ☐ Low maternal weight gain/weight loss
- ☐ Neurological condition
- ☐ Developmental delays (sensory & motor)
- ☐ Food allergies (cow's milk, soy or intact protein)/FPIES
- ☐ Other medical condition*: _____

***The following symptoms are not qualifying conditions and will not be accepted: colic, constipation, spitting up or gas.**

WIC Supplemental Foods (optional)

Unless indicated below, all supplemental foods will be provided. The RD/Nutritionist can also determine foods if left blank.

Infants 6 months of age and older:

- ☐ Formula only, no foods (due to inability or delay in consuming solids)
- ☐ Omit Infant Cereal
- ☐ Omit Baby Foods

Women & Children 12 months of age and older:

- ☐ Formula only, no foods

Omit — check foods to omit from food package

- ☐ Milk ☐ Yogurt ☐ Eggs ☐ Juice ☐ Peanut Butter ☐ Cheese ☐ Cereal
- ☐ Whole Grains ☐ Beans ☐ Fruits and Vegetables ☐ Provide baby foods instead

ISSUE:

- ☐ Whole Milk ☐ 2% Milk

(Must have medical reason)

Please fax this completed form to the WIC clinic or have your patient return it to their WIC clinic

Health Care Provider Information (required)

(MD, DO, PA-C, NP) Signature/Stamp: _____ Date: _____

Provider's Name (please print): _____ Facility Name: _____

Phone: _____ Fax: _____

For WIC use only

WIC Clinic: _____