Family or Participant ID#_____

State of Connecticut WIC Program-Department of Public Health

WIC Medical Documentation for approved special Formula and Approved Foods

WOMEN

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

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.

- ☐ 693.1 Allergy, Food
- ☐ 343.9 Cerebral Palsy
- ☐ 250.01Diabetes Mellitus Type I
- ☐ 271.1 Galactosemia
- ☐ 279.3 Immunodeficiency
- ☐ 646.8 Low Maternal Weight Gain
- ☐ 271.3 Lactose Intolerance
- ☐ 783.2 Maternal Weight Loss During Pregnancy
- ☐ 651 Multifetal Gestation
- ☐ 358.9 Neuromuscular Disorder
- ☐ 270.1 Phenylketonuria (PKU)
- ☐ _____ Other diagnosis with ICD-9 code

Specify _____

Patient must have a diagnosis and not symptoms.

☐ Check here if patient is dually enrolled in HUSKY/Medicaid and the WIC Program. I acknowledge I MUST send a separate prescription with allowable ICD-10 code to the pharmacy for the patient to receive the product. Note: For dually enrolled patients, WIC also requires this form to be completed to ensure continuity of care.

☐ Check here for WIC participants without HUSKY/Medicaid.

Formula requested: _____

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

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**

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 their 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.

- ☐ Milk
- ☐ Soy Milk/Tofu
- ☐ Cheese
- ☐ Yogurt
- ☐ Juice
- ☐ Whole wheat bread /whole grains
- ☐ Breakfast cereal
- ☐ Whole grain pasta
- ☐ Legumes (beans/peas)
- ☐ Eggs
- ☐ Peanut Butter
- ☐ Vegetables and fruits
- ☐ All foods contraindicated
- ☐ Restrictions in amounts: Explain:

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

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

HEALTH CARE PROVIDER SIGNATURE: _____ **Date:** _____

(MD, APRN or PA)

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?** ☐ **Yes** ☐ **No**

WIC Nutritionist Signature: _____ **Date:** ____/____/____