Family or Participant ID#_____

State of Connecticut WIC Program-Department of Public Health

MEDICAL DOCUMENTATION FOR WIC FORMULA AND APPROVED WIC FOODS

INFANTS AND CHILDREN

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

Parent/Guardian: _____ **Weeks Gestation (premature infants):** _____

The Connecticut WIC Program strongly endorses breastfeeding as the optimal method to feed most infants. For infants that do consume formula, Connecticut WIC standard formulas are *Similac® Advance® 20cal/oz.* and *Similac® Isomil® Soy 20cal/oz.* *Similac® Sensitive® 19cal/oz.* and *Similac® Total Comfort® 19cal/oz.* are standard formulas approved in Connecticut requiring medical documentation. 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.

Formula requested: _____

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

☐ Check here to request one of the following: ☐ ***Similac® Sensitive® (19 cal/oz.)*** ***or*** ☐ ***Similac® Total Comfort® (19 cal/oz.)***

☐ Check here to request ***Similac® For Spit-Up® (19 cal/oz.) must have*** documented Gastroesophageal Reflux or Other ICD-10 code.

Instructions for preparation: _____

Caloric density: ☐19cal/oz. ☐ 20cal/oz. ☐ 22cal/oz. ☐ 24cal/oz. ☐ 26cal/oz. ☐ 30cal/oz. ☐ Other: _____

Length of use: ☐1 month ☐ 2 months ☐ 3 months ☐ 4 months ☐ 5 months ☐ 6 months

In order to obtain an exempt/special formula from WIC, an ICD code(s) and qualifying medical condition must be identified. Non-specific symptoms such as intolerance, fussiness, gas, spitting up, constipation and colic are not considered qualifying conditions. A WIC Nutrition Professional will complete a dietary assessment to determine the need for the requested formula. Significant findings will be communicated to you with the participant's permission. It is WIC's policy to re-evaluate the continued need for the formula on a periodic basis. The WIC Program does not provide whole cow's milk for infants. ***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.***

REQUIRED: Select qualifying medical condition(s)/ICD-10 code(s)

☐ Allergy, Food (L27.2	☐ Cystic Fibrosis (E84.9)	☐ Lactose Intolerance (E74.39)
☐ Anemia (D53.9)	☐ Developmental Delay (R62.50)	☐ Malabsorption (K90.9)
☐ Autoimmune Disorder (M35.9)	☐ Diabetes Mellitus Type I (E10.9)	☐ Neuromuscular Disorder (G70.9)
☐ Congenital Heart Disease (Q24.9)	☐ Failure to Thrive/Inadequate Growth (R62.51)	☐ Prematurity (P07.30)
☐ Congenital Anomaly, Respiratory (Q34.9)	☐ Galactosemia (E74.21)	☐ Phenylketonuria (PKU) (E70.0)
☐ Congenital Anomaly, GI (Q45.9)	☐ Gastroesophageal Reflux (K21.9)	☐ Other diagnosis with ICD-10 code
☐ Cleft Palate (Q35.9)	☐ Immunodeficiency (D84.9)	Specify _____
☐ Cerebral Palsy (G80.9)		

Medical Documentation for Whole Milk for Children 2-5 Years of Age:

If child is over 2 years of age, does he/she require whole milk based on a qualifying condition? ☐ **Yes** ☐ **No**

Children age 2 or older 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.

Medical Documentation for Fat-Reduced Milks for Children 12-23 Months of Age:

If the child is 12-23 months of age does he/she require fat reduced milk based on overweight or obesity? ☐ **Yes** ☐ **No** **Specify:** _____

Please specify 2%, 1% or skim. Whole milk is the standard milk given to children 12-23 months of age. Fat-reduced milk (2%, 1% or skim) can be provided for children 12-23 months when overweight or obesity is a concern.

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

☐ Milk, Specify type: _____	☐ Whole wheat bread /whole grains	☐ Peanut butter	☐ All foods contraindicated
☐ Soy Milk/ Tofu	☐ Breakfast cereal	☐ Vegetables and fruits	☐ Restrictions in amounts:
☐ Cheese	☐ Whole grain pasta	☐ Infant cereal	Explain: _____
☐ Yogurt	☐ Legumes (beans/peas)	☐ Infant food vegetables/ fruits	_____
☐ Juice	☐ 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:** ____/____/_____

(MD, APRN or PA)

Printed Name (Health Care Provider): _____ Phone: _____

Provider Stamp or Address: Fax:

WIC Use Only: Date received ____/____/_____ **Contacted HCP?** **Yes** ☐ **No** ☐

CPA Signature: _____ **Date:** ____/____/_____