CONNECTICUT WIC PROGRAM
SPECIAL FORMULA REVIEW FORM

Name: ______________________ Family ID # _______________ Category ______ DOB _________

Weeks gestation _______ BF Status _________ Prescription ___________________________________

Local Program ________________________________ Reviewer _____________________________

	YES	NO	NA	COMMENTS
REQUEST FOR SPECIAL FORMULA FORM				
Reason for Issuance				
Length of Issuance				
Date of Request				
ICD-Code				
WIC Foods Not Allowed Documented				
Physician Signature				
CARE PLAN				
Formula Intolerance Assessed				
Nutrition Education/ Counseling Provided				
Risk Screen Updated				
Appropriate Food Package Issued				
Months Issued Appropriate				
MD Consultation/Follow-Up as Needed				

*Adapted from Massachusetts WIC Program