State of Vermont WIC Program

MEDICAL DOCUMENTATION FOR WIC FORMULA AND APPROVED WIC FOODS

WOMEN

1. Patient Information

Name: ____**Date of Birth:** __/___ /___

2. Qualifying medical condition(s)

Select the diagnosed medical condition(s) and ICD-10 code(s) justifying the formula/medical food prescription:

- ☐ Allergy, Food (Z91.01) specify food: _______________
- ☐ Failure to Thrive: Adult (R62.7)
- ☐ Gastrointestinal Disorder (specify): __________ ICD-10: _______
- ☐ Gastroesophageal Reflux (K21.9)
- ☐ Immune Disorder (specify): _____________ ICD-10: _______
- ☐ Inborn Errors of Metabolism/Metabolic Disorders (270-279) Specify: ______________
- ☐ Lactose Intolerance (E73)
- ☐ Low Weight Gain in Pregnancy (O26.1)
- ☐ Malabsorption syndromes (K90) Specify: _____________
- ☐ Other, specify: ___________________ ICD-10:__________

Note: WIC approval and provision of formulas and medical foods are based on Vermont WIC program policies and procedures.

3. Formula or medical food

Product requested: ____

Prescribed amount per day* _______ OR ☐ ad lib

Product form: ☐ Powder ☐ Concentrate ☐ Other:

Length of use: ☐ During pregnancy ☐ Postpartum/Breastfeeding

Special instructions: ____

***WIC is a supplemental nutrition program and may not provide the total amount of formula or food prescribed**

4. WIC Supplemental Foods

The patient will receive supplemental foods in addition to the formula indicated. Please indicate if **all foods are allowed** or indicate any supplemental foods **contraindicated** by the patient's medical diagnosis.

☐ All foods are allowed

OR

Foods contraindicated:

- ☐ Breakfast cereal
- ☐ Eggs
- ☐ Beans
- ☐ Peanut butter
- ☐ Dairy products
- ☐ Juice
- ☐ Vegetables and Fruits
- ☐ Whole grains
- ☐ Soy products
- ☐ Canned fish

5. WIC Authorization

☐ By checking this box, I authorize the WIC Nutrition Professional to determine any future appropriate supplemental foods and amounts, ***excluding*** formula/medical foods.

6.	**HEALTH CARE PROVIDER SIGNATURE** (MD, APRN or PA):	**Date:**
Printed Name or Stamp (Health Care Provider):		
Medical Office/Clinic/Hospital:		Phone:
Address:		Fax:

Instructions for Physicians or Physician Assistants or Nurse Practitioners

(Only Healthcare Providers licensed to write a prescription in Vermont can complete this form)

Item #1: Write patient's complete name and date of birth.

Item #2: Document one or more of the patient's qualifying medical condition(s) and ICD-10 diagnosis code(s).

Item #3: Indicate the formula or medical food requested, any special instructions and the intended length of use. It is WIC's policy to re-evaluate the participant's continued need for the formula on a periodic basis. Physical forms routinely provided by WIC are powder or concentrate. Ready-to-Feed (RTF) formula or medical foods may be authorized when the product is only available in ready-to-feed, when WIC nutrition staff determines and documents that there is an unsanitary or restricted water supply or poor refrigeration, or the participant has difficulty in correctly diluting the concentrated liquid or powdered formula.

Item #4 The patient will also receive supplemental foods from the WIC Program, appropriate to their participant category in addition to the formula indicated. Please indicate if **all foods are allowed** or indicate any supplemental foods **contraindicated** by the patient's medical diagnosis. Prescription renewal may be required periodically, based on medical condition.

Item #5 Providing **WIC Authorization** allows the WIC Nutrition Professional to determine any future additions or subtractions to the supplemental foods provided by the WIC Program. This authorization does not include medical formulas or medical food.

Item #6 A Health Care Provider's **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 nutritional needs and determined she has a serious medical condition. Give the completed form to the patient to take to their local WIC program or fax or mail to the WIC office serving the patient.

For more information or additional copies of this form visit the
Vermont Health Department website at
http://www.healthvermont.gov/children-youth-families/wic/resources-health-professionals

WIC Office Use: **WIC Staff Signature:** ______________________________ **Date:** ______________
WIC Staff instructions: Review form for completeness. If there are questions, before approving the prescription, contact the participant's health care provider to resolve. Sign and date form.

WIC is an equal opportunity provider.