

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:

<input type="checkbox"/> Allergy, Food (Z91.01) specify food: _____ <input type="checkbox"/> Failure to Thrive: Adult (R62.7) <input type="checkbox"/> Gastrointestinal Disorder (specify): _____ ICD-10: _____ <input type="checkbox"/> Gastroesophageal Reflux (K21.9) <input type="checkbox"/> Immune Disorder (specify): _____ ICD-10: _____	<input type="checkbox"/> Inborn Errors of Metabolism/Metabolic Disorders (270-279) Specify: _____ <input type="checkbox"/> Lactose Intolerance (E73) <input type="checkbox"/> Low Weight Gain in Pregnancy (O26.1) <input type="checkbox"/> Malabsorption syndromes (K90) Specify: _____ <input type="checkbox"/> Other, specify: _____ ICD-10: _____
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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:

- | | |
|---|--|
| <input type="checkbox"/> Breakfast cereal | <input type="checkbox"/> Juice |
| <input type="checkbox"/> Eggs | <input type="checkbox"/> Vegetables and Fruits |
| <input type="checkbox"/> Beans | <input type="checkbox"/> Whole grains |
| <input type="checkbox"/> Peanut butter | <input type="checkbox"/> Soy products |
| <input type="checkbox"/> Dairy products | <input type="checkbox"/> 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.