WEST VIRGINIA WIC

WEST VIRGINIA Department of Health & Human Resources

# West Virginia WIC Program
# Prescription Formula Form
**For Prescribed Formulas and Foods**

For medical formula/foods, complete section A.
For a 19 calorie infant formula, complete section B.
For all patients, if applicable, complete section C.
For a soy-based beverage for children, complete section D.

Please fax form to WIC clinic or have WIC participant return form to clinic.

## Patient Information

**Patient's Full Name:** | **DOB:**

**Caregiver's Name:**

## A. Medical Formula/Medical Foods

**Medical Reason/Diagnosis:**

**Formula requested:** **Prescribed amount: _____ oz/day**

**Prescribed Form:** ☐ Powder ☐ Concentrate ☐ Ready-to-feed

**Time needed:** ☐ 1 month ☐ 2 months ☐ 3 months ☐ 4 months ☐ 5 months ☐ 6 months

## B. 19 Calorie Infant Formula (Similac Sensitive [not available in concentrate form], Similac for Spit-Up, or Similac Total Comfort)

**Medical Reason/Diagnosis:**

**Formula requested:** **Prescribed amount: _____ oz/day**

**Prescribed Form:** ☐ Powder ☐ Concentrate ☐ Ready-to-feed

**Time needed:** ☐ 1 month ☐ 2 months ☐ 3 months ☐ 4 months ☐ 5 months ☐ 6 months

## C. Supplemental Foods

In addition to the infant formula/medical food, supplemental foods appropriate to the WIC participant category will be provided. Please mark the appropriate boxes below to indicate any foods that would be contraindicated with the patient's medical diagnosis.

☐ **No supplemental foods at this time:** omit all supplemental foods and provide formula/medical food ONLY.

| WIC Participant Category | WIC Supplemental Foods Available | Do Not Give | Restrictions/Special Instructions |
|---|---|---|---|
| **Infants** 6-11 months | Infant cereal | | |
| | Infant fruits/vegetables | | |
| **Children** -and- **Women** | Milk | | |
| | Cheese | | |
| | Eggs | | |
| | Juice | | |
| | Breakfast cereals | | |
| | Legumes and/or peanut butter | | |
| | Fruits and vegetables | | |
| | Whole grains | | |
| | Fish (exclusively breastfeeding women only) | | |

## D. Soy-based Beverage for Children

Mark the qualifying condition that justifies the need for soy beverage as a milk substitute:
☐ Milk allergy ☐ Severe lactose intolerance ☐ Vegan diet ☐ Other (specify) _____

## E. Health care provider information

**Provider's name** (please print): ☐ **MD** ☐ **PA** ☐ **DO** ☐ **NP**

**Medical office/clinic:**

**Phone #:** **Fax#:** **Date:**

**Signature of health care provider:**

**WIC USE ONLY** | **Approved by:** | **Date:**