

# WEST VIRGINIA WIC PROGRAM

## Prescription Formula Form for Prescribed Formulas and Foods

Section A: Complete for Exempt, 19 Calorie Formula or Nutritional

Section B: Complete for all patients, if applicable

Section C: Complete for all patients

Please fax completed form to WIC Clinic or have Parent/Guardian return to WIC Clinic

PATIENT INFORMATION			
Patient's Full Name:		DOB:	
Parent/Guardian Name:			
A. EXEMPT FORMULA OR 19 CALORIE FORMULA ( <i>Similac Sensitive for Fussiness &amp; Gas, Similac for Spit-up, Similac Total Comfort</i> ) OR WIC-ELIGIBLE NUTRITIONAL			
Medical Reason/Diagnosis:			
Formula Requested:		Prescribed Amount: oz./day	
Prescribed Form: <input type="checkbox"/> Powder <input type="checkbox"/> Concentrate <input type="checkbox"/> Ready to Feed		<input type="checkbox"/> Formula Change or <input type="checkbox"/> Renewal	
Time Needed: <input type="checkbox"/> 1 Month <input type="checkbox"/> 2 Months <input type="checkbox"/> 3 Months <input type="checkbox"/> 4 Months <input type="checkbox"/> 5 Months <input type="checkbox"/> 6 Months			
B. SUPPLEMENTAL FOODS			
In addition to the infant formula/nutrionals, supplemental foods appropriate to the WIC participant category will be provided. Please mark the appropriate boxes below to indicate any foods that would be <u>contraindicated</u> with the patient's diagnosis.			
<input type="checkbox"/> No Supplemental foods at this time: Omit all supplemental foods and provide formula or nutritional <u>ONLY</u> .			
WIC Category	WIC Supplemental Foods Available	Do Not Give	Restrictions/Special Instructions
Infants 6 – 11 months	Infant Cereal		
	Infant Fruits/Vegetables		
Children and Women  <i>* Please note: Fish is only for fully breastfeeding women, women who are pregnant with multiples and pregnant women who are breastfeeding.</i>	Milk		
	Cheese		
	Eggs		
	Juice		
	Breakfast Cereals		
	Legumes and/or Peanut Butter		
	Fruits and Vegetables		
	Whole Grains		
	*Fish		
C. HEALTH CARE PROVIDER INFORMATION			
Health Care Provider's Name (Please Print):			MD DO NP PA
Medical Office/Clinic:			
Phone Number:		Fax Number:	
Signature of Health Care Provider:			Date:
WIC USE ONLY			
Approved by:			Date: