



West Virginia WIC Program Prescription Formula Form For Medical Formulas and Foods

Please complete sections A and D for all patients.

For medical formula/foods, complete section B.

For soy-based beverage for a child, complete section C

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

A. Patient information

Patient's Name (Last, First, MI):	DOB:
Caregiver's name	
Medical Reason/Diagnosis:	
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. Medical formula/medical food and WIC supplemental foods

Formula requested:	
Prescribed amount per day _____ oz/day	Form: <input type="checkbox"/> Powder <input type="checkbox"/> Concentrate <input type="checkbox"/> Ready-to-feed
<p>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.</p> <p><input type="checkbox"/> No supplemental foods: Offering food is contraindicated at this time; omit all supplemental foods and provide formula only.</p>	

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)		

C. Soy-based beverage

To authorize soy-based beverage for a child check here

Mark the qualifying condition that justifies the need for soy beverage as a milk substitute.

Milk allergy Severe lactose intolerance Vegan diet Other (specify) _____

D. Health care provider information

Provider's name (please print):	<input type="checkbox"/> MD <input type="checkbox"/> PA <input type="checkbox"/> DO <input type="checkbox"/> NP
Medical office/clinic:	
Phone #:	Fax#:
Date:	
Signature of health care provider:	
WIC USE ONLY	Approved by:
Date:	