

**State of Connecticut WIC Program-Department of Public Health**  
MEDICAL DOCUMENTATION FOR WIC FORMULA AND APPROVED WIC FOODS  
**WOMEN**

1. Patient's First & Last Name: \_\_\_\_\_  
Date of Birth (DOB): \_\_\_/\_\_\_/\_\_\_

*Prescription is subject to WIC approval and provision is based on Program policy and procedure.*

2. Please check qualifying medical condition(s)/ICD-9 code(s)

- |  |  |
|--|--|
| <input type="checkbox"/> 693.1 Allergy, Food             | <input type="checkbox"/> 783.2 Maternal Weight Loss During Pregnancy |
| <input type="checkbox"/> 343.9 Cerebral Palsy            | <input type="checkbox"/> 651 Multifetal Gestation                    |
| <input type="checkbox"/> 250.01 Diabetes Mellitus Type I | <input type="checkbox"/> 358.9 Neuromuscular Disorder                |
| <input type="checkbox"/> 271.1 Galactosemia              | <input type="checkbox"/> 270.1 Phenylketonuria (PKU)                 |
| <input type="checkbox"/> 279.3 Immunodeficiency          | <input type="checkbox"/> _____ Other diagnosis with ICD-9 code       |
| <input type="checkbox"/> 646.8 Low Maternal Weight Gain  | Specify _____  |
| <input type="checkbox"/> 271.3 Lactose Intolerance       |  |

3. Formula requested: \_\_\_\_\_

Prescribed ounces per day\* (unless ad lib): \_\_\_\_\_  Powder  Concentrate  Other \_\_\_\_\_

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

Instructions for preparation: \_\_\_\_\_

Caloric density (e.g. 20cal/oz; 24 cal/oz; 30 cal/oz) \_\_\_\_\_

Length of use:  1 mo  3 mos  6 mos

**Note:** The patient will receive supplemental foods, appropriate to their age and participant category in addition to the formula indicated. Please check any supplemental foods **contraindicated** by the patient's medical diagnosis. If there are only restrictions to amounts of supplemental foods provided due to medical diagnosis, check box and explain in the space provided. Prescription renewal is required periodically, based on medical condition. **No prescription is valid for more than six months.**

4. WIC Supplemental Foods Available Check foods that are **contraindicated** based on medical diagnosis

- |   |  |
|---|--|
| <input type="checkbox"/> Breakfast cereal   | <input type="checkbox"/> Vegetables and Fruits                           |
| <input type="checkbox"/> Eggs   | <input type="checkbox"/> Whole wheat bread or other allowed whole grains |
| <input type="checkbox"/> Juice  |  |
| <input type="checkbox"/> Legumes or peanut butter                                 |  |
| <input type="checkbox"/> Milk; Specify: _____ or Milk substitutes; Specify: _____ |  |

All food contraindicated

Restriction(s) in amounts?

Explain:

Length of use:  1 mo  3 mos  6 mos

5. Milk substitute(s) requested: Tofu and cheese above the WIC maximum substitution amounts requires a qualifying condition.

Tofu  Cheese Amount per day: \_\_\_\_\_

Length of use:  1 mo  3 mos  6 mos

6. HEALTH CARE PROVIDER SIGNATURE:

(MD, APRN or PA)

Date:

Printed Name (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 Connecticut can complete this form)

- Item #1:** Write patient’s complete name and date of birth (DOB).
- Item #2:** From the list of most common nutrition related ICD-9 medical diagnoses determine and document one or more of the patient’s serious qualifying medical condition(s) for which WIC prescriptions may be written. Other medical diagnosis that may require special/exempt infant formulas must have an ICD-9 code and will be considered on a case by case basis.
- Item #3:** Indicate the special/exempt formula requested instructions for preparation and intended length of use. It is WIC’s policy to re-evaluate the participant’s continued need for the formula on a periodic basis. No prescription is valid for more than six months.  
**For cost containment purposes,** physical forms routinely provided by WIC are powder or concentrate forms. 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 may have difficulty in correctly diluting the concentrated liquid or powdered formula.
- Item #4** The patient will receive supplemental foods from the WIC Program, appropriate to their participant category in addition to the formula indicated. Please check any supplemental foods **contraindicated** by the patient’s medical diagnosis. If there are only restrictions to amounts of supplemental foods provided due to medical diagnosis, check box and explain in the space provided. Prescription renewal is required periodically, based on medical condition.
- Item #5** Provision of calcium-set (fortified) tofu in amounts **over 4 pounds** (for all women) or provision of cheese in amounts **over 1 pound** (for pregnant, partially breastfeeding or formula feeding women) or **amounts over 2 pounds** (for fully breastfeeding women) requires a qualifying condition such as lactose intolerance or other medical diagnosis. Medical documentation is not needed for cheese substitutions of 1 pound or less. If either of these foods are needed, indicate the amount prescribed per day and the intended length of use.
- Item #6** A Health Care Provider’s **original 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 nutrition and feeding problem(s) and symptoms determining, he/she has a serious medical condition. Give the completed form to the parent/guardian to take to their local WIC program or fax to the clinic serving the patient.

**For more information or additional copies of this form please visit our website:** [www.ct.gov/dph/wic](http://www.ct.gov/dph/wic), then click on “For Medical Providers” tab in the left navigation bar.

<b>WIC Office Use:</b>	
<b>CPA Signature:</b> _____	<b>Date:</b> _____
<b>WIC Staff instructions:</b> 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. If formula is not available retail, complete formula request form as outlined in the State Plan/policies and fax to the State WIC Office.	

**WIC is an equal opportunity provider.**