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| Minnesota WIC Program  **Request for Medical Formula** | Household ID # |  |
| State WIC ID# |  |

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| The WIC Program requires a medical diagnosis to provide a medical formula/food and/or to change the WIC food package. All requests are subject to WIC approval. | |
| Return completed form to the WIC clinic or have your patient return the form to the WIC clinic. | |
|  | FAX #: 952-891-7568, Attention: WIC Registered Dietitian, 952-891-7525 |
|  | OR mail to: Dakota County Public Health–WIC, 14955 Galaxie Ave., Apple Valley, MN 55124 |

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| **A. Patient Information - REQUIRED:** | | | | | |
| (First)  Patient’s Name: | | | (Last) | | DOB: |
| (First)  Parent / Caregiver's Name: | | | (Last) | | |
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| **B. Medical Formula - REQUIRED** | | | | | |
| Formula Requested: | | | | | |
| **C. Qualifying Medical Reason - REQUIRED** *(check all that apply)* | | | | | |
| Prematurity | Gastrointestinal Disorders | | Severe Food Allergies | | |
| Low Birth Weight | GERD/Reflux | | Failure to Thrive (specify underlying medical condition) | | |
| Other Condition (describe): | | | | | |
| If not specified, up to (but not more than), WIC maximum allowable may be provided. Maximum allowed might not meet patient’s full need. | | Amount Needed per Day**:** | | | |
| Standard preparation, unless otherwise specified | | Preparation / Feeding Instructions: | | | |
| Note: If no length specified, may provide up to 6 months. All prescriptions re-evaluated every 6 months. | | Intended Length of Use:  1 month  2 months  3 months  4 months  5 months  6 months | | | |
| **D. WIC Supplemental Foods** | | | | | |
| **Standard Food Package** (If no changes are specified, standard foods will be provided.)  **Infants** (6-12 months) will receive infant cereal and infant fruits/vegetables  **Children** (12-60 months) and **Women** will receive milk, cheese, juice, fruits/vegetables, whole grains, eggs, legumes, peanut butter, cereal, (canned fish breastfeeding women only) | | | | | |
| **Provide** age appropriate WIC foods. **Exceptions (specify):** | | | | | |
| **Omit all** supplementalWIC foods, and provide medical formula only. | | | | | |
| For child (age 1-4) receiving medical formula, provide infant fruits/vegetables | | | | | |
| Provide whole milk. Only patients receiving medical formula and who need additional calories may receive whole milk. | | | | | |
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| **E. Health Care Provider Information - REQUIRED** | | | | | |
| Health Care Provider Signature: | | | | Date: | |
| Provider’s Name*: (please print)* | | | | MD  NP  PA  CNM DO | |
| Medical Office: | | | |  | |
| Phone #: | | | | Fax #: | |