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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 #: |