D.C. WIC Medical Documentation & Referral Form for WOMEN, INFANTS & CHILDREN

This form is used for referring clients to WIC or special dietary requests. Complete one form for each participant.

Patient's Name _____ Date of Birth _____

Address _____ City _____ Zip code _____

Parent / Caregiver's name _____ Telephone _____

Medical Data:

DATE MEASURED	LENGTH / HEIGHT	WEIGHT	DATE MEASURED	HGB OR HCT	DATE MEASURED	GLUCOSE (IF GESTATIONAL DIABETIC)	DATE MEASURED	BLOOD LEAD LEVEL

Women (pregnant, nursing, or less than six months postpartum):

Pregnant / Estimated date of delivery: _____

Multi-fetal Gestation ☐Yes ☐ No

Pre-pregnancy wt _____

Feeding Plan

- ☐ Fully breastfeeding
- ☐ Combination of feeding: Breast milk and formula
- ☐ Do not recommend breastfeeding due to the following medical diagnosis:

_____

Postpartum / Date pregnancy ended: _____

Infants and Children ☐ Female ☐ Male

Birth History: ☐ SGA ☐ LGA

Birth Weight _____ lb _____ oz OR _____ kg

Birth Length _____ inches OR _____ cm

Weeks of Gestation _____

Feeding Prescription

- ☐ Fully breastfeeding
- ☐ Combination of feeding: Breast milk and formula
- ☐ Do not recommend breastfeeding due to the following medical diagnosis: _____

If no special formula or diet is requested, stop here and sign the back of this form

Patients will receive supplemental foods (appropriate to their age and participant category) in addition to formula indicated. Prescription renewal is required periodically based on age, medical condition and nutrition assessment.

Formula/Supplement/Medical Food Request (Requires MD/DO/PA/CNP/CNM signature on back)

Formula Name: _____

Amount needed: _____ ounces per day _____ calories per ounce

Length of time: ☐ 3 months ☐ 6 months ☐ Other_____

Additional instructions:

Other infant formula(s) tried so far (include basic infant formula if used)			
Name	**Date started**	**Date ended**	**Results**

☐ **Medically contraindicated for infant to try formula(s) other than the one prescribed.**

A special request formula for infants will be considered only when Similac Advance or Enfamil Prosobee are inappropriate due to a documented medical reason.

WIC cannot provide the following non-contract formulas, even with medical documentation:

- Any low iron formula
- Enfamil Premium or Similac Isomil
- Similac Sensitive for Fussiness and Gas

The following are inappropriate reasons to prescribe a special formula:

Fussiness / spitting up / gas / constipation / lactose intolerance / a non-specific formula or food intolerance / participant preference / solely for the purpose of enhancing nutrient intake / managing body weight without a medical condition

Please continue and sign on back page

Please indicate any foods that WIC should not give this patient (Requires MD/DO/PA/CNP/CNM signature).

WIC Supplemental Foods Available	Do **Not** Give	WIC Supplemental Foods Available	Do **Not** Give
Infant Cereal		Vegetables / Fruits (specify below)	
Infant Food Vegetables/Fruits		Eggs	
Infant Meat *		Whole Wheat Bread	
Milk		Corn Tortillas	
Whole Oats		Brown Rice	
Cheese		Dried Beans, Peas, Lentils	
Cereal		Peanut Butter	
Juice		Canned Fish *	
Canned Vegetables		Canned Beans	

Please indicate reason for restriction: ☐ Food Allergy: type_____
☐ Severe lactose maldigestion ☐ Vegan diet ☐ Other:_____

* Fully Breastfeeding moms and infants are the only WIC participants eligible to receive infant meats and canned fish.

☐ **Issue whole milk:** WIC provides reduced fat milk (2%, 1%, or skim) for *children from 2 – 5 years old and women*. Whole milk may be issued to those with qualifying medical conditions which **also require the use of a special formula/medical food.**

☐ **Issue milk substitutes for children (1 – 5 years old) with a qualifying condition:**

_____ **Yes, issue soy milk**	_____ **Yes, issue tofu**	_____ **Yes, issue more than 1 pound of cheese per month**
_____ Maximum amount (up to 16 quarts per month) allowed; allow participant to decide amount. _____ Limit amount; specify amount per month: _____	_____ Maximum amount (up to 16 pounds per month) allowed; allow participant to decide amount. _____ Limit amount; specify amount per month: _____	_____ Maximum amount (up to 5 pounds per month) allowed; allow participant to decide amount. _____ Limit amount; specify amount per month: _____

Issue soy milk or tofu for: ☐ Milk Allergy ☐ Severe Lactose Maldigestion ☐ Religious Reasons ☐ Vegan Diet
Issue additional cheese for: ☐ Severe Lactose Maldigestion ☐ Other:_____

☐ **Issue more than 1 pound of cheese or 4 # of tofu per month to woman.** With qualifying medical conditions women may receive additional cheese or tofu as a substitute for milk (See attachment for maximum allowance).
Prescribed amount: _____ maximum amount allowed for cheese and tofu; allow participant to decide amount
_____ Limit amount to: _____ pounds cheese per month or _____ pounds tofu per month
Indicate reason: ☐ Milk Allergy ☐ Severe Lactose Maldigestion ☐ Other:_____

☐ **Issue infant extra formula (6 months and older).** Infants older than 6 months with medical conditions preventing them from consuming baby foods (cereal, fruit and vegetables) may receive additional special formula.

☐ **Issue infant cereal to child** (instead of regular hot & cold cereal – **must also be receiving special formula**).

Additional comments / special instructions:

Please check qualifying medical condition (s): Justifies requested formula / medical food ☐ Allergy Risk Reduction
☐ Premature birth ☐ Low Birth weight ☐ Failure to Thrive ☐ Metabolic disorders ☐ Gastrointestinal disorders
☐ **GERD (Similac for Spit UP will only be authorized for GERD)** ☐ Malabsorption Syndrome ☐ Immune system disorders ☐ Food allergy ☐ Dysphagia

Provider's name (Please Print):	**Signature**:

Credential: ☐ **MD** ☐ **DO** ☐ **PA** ☐ **CNP** ☐ **CNM (**Certified Nurse Midwife**)**
(Please check) ☐ **RD** ☐ **LD** ☐ **RN** ☐ **LPN** ☐ **LSW**

Signature of **MD / DO / PA / CNM / CNP required if requesting special formula or dietary change.**
Signature of **RD / LD / RN / LPN / LSW when providing medical data only.**
Date _____ Medical Office / Clinic:_____
Address_____
Phone number _____ Fax number _____

PLEASE RETAIN A COPY FOR YOUR RECORDS AND GIVE ORIGINAL FORM TO WIC CLIENT or FAX TO THE WIC CLINIC.
CALL 202-442-9397 FOR THE MOST CURRENT DC WIC CLINIC LISTING.

For WIC use only:
Date Received: _____ ☐ Telephone request (follow-up written Rx within 1 month)
Comments: _____ CPA Signature _____