# 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 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 MEASURED | 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.***

**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_____

**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:

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

| **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 Gerber Good Start Soy are inappropriate due to a documented medical reason.**
**WIC cannot provide the following formulas, even with medical documentation:**
- Any low iron formula
- Enfamil Premium of Similac Isomil
- Premium Newborn for supplementation
- Enfamil Prosobee

**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**

| 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 | |
| Yogurt | | | |

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

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

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

❑ **Issue fat-reduced milk: WIC provides whole milk for *children 12 months – 24 months old***. Fat-reduced milks (2%, 1% or fat free) may be used to one year olds at risk of overweight or obesity.

❑ **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).

❑ **Issue infant fruits and vegetables (pureed) to woman or child-** 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 or Low Birth weight ❑ Failure to Thrive ❑ Metabolic disorders ❑ Gastrointestinal disorders
❑ Malabsorption Syndrome ❑ Immune system disorders ❑ Food allergy ❑ Dysphagia ❑ Overweight/Obesity
❑Other(s):_____

| **Provider's Name (Please Print):** | **Signature:** |
|---|---|

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**(Please check)** ❑ **RD** ❑ **LD** ❑ **RN** ❑ **LPN** ❑ **LSW**

Signature of **MD / DO / PA / CNM / CNP required if requesting special formula or dietary change**
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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 OR GO TO HTTP://DOH.DC.GOV/SERVICE/SPECIAL-SUPPLEMENTAL-NUTRITION-PROGRAM-WOMEN-INFANTS-AND-CHILDREN-WIC 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_____