Texas WIC Medical Request for Contract Formula/Food

For all other formula requests use reverse side.

All requests are subject to WIC approval and provision based on program policy and procedure.

See the Texas WIC Formulary at http://www.dshs.state.tx.us/wichd/nut/pdf/TXWICFormulary.pdf.

Required Patient Information

Patient's Last Name: _____ First Name: _____ DOB: _____

Parent/Caregiver's Name: _____

Similac Advance is the formula provided to all infants on WIC. If **Similac Advance** is not tolerated, alternate formulas may be provided.

Check below to request an alternate WIC formula due to formula intolerance:

- ❒ **Similac Sensitive – for lactose sensitivity and/or colic**
- ❒ **Similac for Spit Up – for spitting up and/or reflux** (Medical Request not required until June 1st, 2014)
- ❒ **Similac Total Comfort – for digestive issues and/or colic** (Medical Request not required until June 1st, 2014)

Unable to trial Similac Advance due to severe or exceptional medical condition listed here: _____

Formula amount: _____ per day (Maximum allowed by federal guidelines will be provided unless a lesser amount is indicated.)

Number Months: _____ (Will be issued up to 12 months of age unless otherwise indicated.)

Infants (6-12 months old)

Full provision of formula and infant foods will be issued unless checked below.

❒ **Provide only formula past 6 months of age due to inability or delay in consuming solids.**
Infants unable to eat **and** on therapeutic (non-standard) formula may be eligible for an increased amount of formula.

Check WIC Supplemental Food to *OMIT at 6 months of age.*

❒ Infant Cereal	❒ Baby Food (fruits and/or vegetables)

Children (1-5 years old) and Women

All appropriate WIC foods, except milk, will be issued with prescribed formula unless checked below.

❒ **Provide milk** in addition to formula.
❒ **Provide soy milk/tofu** in addition to formula for milk allergy.
❒ **No supplemental foods.** Provide formula only.

Check WIC Supplemental Foods to *OMIT* from Food Package.

❒ Cheese	❒ Peanut Butter	❒ Cereal	❒ Juice
❒ Eggs	❒ Beans	❒ Whole Grains	❒ Fruits/Vegetables

Health Care Provider Information (Signature and all information below required to process request):

Signature/Stamp of Health Care Provider (MD, DO, PA, NP): _____ **Date:** _____

Provider's Name (Please Print): _____ Clinic/Practice Name: _____

Phone Number: _____ Fax Number: _____

For WIC Use Only

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Texas WIC Medical Request for Formula/Food

For alternate contract formula requests use reverse side.
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See the Texas WIC Formulary at http://www.dshs.state.tx.us/wichd/nut/pdf/TXWICFormulary.pdf.

Required Patient Information

Patient's Last Name: _____ First Name: _____ DOB: _____

Parent/Caregiver's Name: _____

Name of Formula: _____

Requested length of issuance: ❒ 3 months ❒ 6 months Other: _____ **Formula amount:** _____ **per day***

*Maximum allowed by federal guidelines will be provided unless a lesser amount is indicated.

Qualifying Condition/Diagnosis: _____

Date of Measurements: _____

Measurements: Length/Height: _____ Weight: _____ **If premature:** Birth Weight: _____ Weeks Gestation: _____

A retrial of contract WIC formula (Similac Advance, Gerber Good Start Soy) will occur up to a maximum of 3 months after the non-WIC formula has been provided. (Does not apply to therapeutic formulas.)

This retrial may be waived for severe or exceptional medical conditions. Please state condition(s) here:

Infants (6-12 months old)

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Check WIC Supplemental Food to *OMIT at 6 months of age.*

❒ Infant Cereal	❒ Baby Food (fruits and/or vegetables)

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All appropriate WIC foods, except milk, will be issued with prescribed formula unless checked below.

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Check WIC Supplemental Foods to *OMIT* from Food Package.

❒ Cheese	❒ Peanut Butter	❒ Cereal	❒ Juice
❒ Eggs	❒ Beans	❒ Whole Grains	❒ Fruits/Vegetables

Health Care Provider Information (Signature and all information below required to process request):

Signature/Stamp of Health Care Provider (MD, DO, PA, NP): _____ **Date:** _____

Provider's Name (Please Print): _____ Clinic/Practice Name: _____

Phone Number: _____ Fax Number: _____

For WIC Use Only

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