For Infants Only (Side One)
Texas WIC Medical Request for Formula/Food

For women and children formula/food requests, use the reverse side.
All requests are subject to WIC approval and provision based on program policy and procedure.
Please fax the completed form to the WIC clinic or have your patient return the document to their WIC Clinic.

Required Patient Information

Patient's Name (First, Last, MI):_____ DOB:_____

Parent/ Caregiver's Name:_____ Phone Number:_____

Alternate Similac WIC Formulas

Similac Advance and Good Start Soy are the formulas provided to infants on WIC. If Similac Advance is not tolerated, alternate formulas may be requested.

Check below to request an alternate WIC formula due to formula intolerance to Similac Advance or Good Start Soy:

☐ Similac Sensitive-for lactose sensitivity and/or colic
☐ Similac for Spit Up-for excessive spitting up and/or reflux
☐ Similac Total Comfort-for digestive issues and/or colic

Maximum allowed by federal guidelines will be provided unless a lesser amount is indicated here: Formula Amount _____ per day

Formula will be issued to 12 months of age unless a shorter time period is indicated here: Requested Length of issuance _____

A trial of Similac Advance is contraindicated due to the following severe and exceptional medical condition(s): _____

_____

Other Formulas

Name of Formula:_____

Qualifying Condition/Diagnosis:_____

Requested length of issuance:
☐ 3 months ☐ 6 months ☐ Other:_____

Maximum allowed by federal guidelines will be provided unless a lesser amount is indicated below:

Formula Amount _____ per day

Note: Non-WIC standard formulas are not provided for formula intolerance symptoms such as spit-up, colic, constipation or gas.

A retrial of WIC contract formula will occur up to a maximum of 3 months after the non-WIC formula has been provided. (Does not apply to therapeutic formulas.) If a retrial is medically contra-indicated, please state reason here:

_____
_____
_____
_____
_____

Date of measurements:_____

Length/Height:_____ Weight:_____ If Premature: Birth Weight:_____ Weeks Gestation:_____

WIC Supplemental Foods (at 6 months of age)

Unless indicated below, all supplemental foods will be provided. The RD/Nutritionist can determine the appropriate supplemental foods and amounts if left blank.

☐ Formula only (no foods and increased amount of formula past 6 months of age due to inability or delay in consuming solids).

☐ Omit –The foods indicated here need to be omitted from my patients' WIC food Package: ☐ Infant Cereal ☐ Baby Foods

Health Care provider information (signature/stamp and all information below required to process request)

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

Provider's Name (please print)_____ Medical Office/Clinic_____

Phone: _____ Fax:_____

For WIC Use Only

WIC Clinic: _____ **Phone:**_____ **Fax:** _____