

Name \_\_\_\_\_ Birthdate \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ ZIP \_\_\_\_\_

Height \_\_\_\_\_ Weight \_\_\_\_\_ ICD-9 code \_\_\_\_\_

Parent/Guardian \_\_\_\_\_

**Medical Diagnosis** (Check all that apply):

- |                                                                |                                                                |                                                                                   |
|----------------------------------------------------------------|----------------------------------------------------------------|-----------------------------------------------------------------------------------|
| <input type="checkbox"/> Breast Milk Fortification (Preterm)   | <input type="checkbox"/> Inflammatory Bowel Disease            | <input type="checkbox"/> Complication that impairs nutrient absorption/metabolism |
| <input type="checkbox"/> Colitis                               | <input type="checkbox"/> Irritable Bowel Syndrome              | <input type="checkbox"/> Eating Disorder                                          |
| <input type="checkbox"/> Crohn's Disease                       | <input type="checkbox"/> Seizure Disorders                     | <input type="checkbox"/> Postoperative Care                                       |
| <input type="checkbox"/> Cystic Fibrosis                       | <input type="checkbox"/> Lactose Intolerance/Lactose Free      | <input type="checkbox"/> Condition Requiring Readily Digestible Nutrients         |
| <input type="checkbox"/> Diarrhea                              | <input type="checkbox"/> Milk Protein Sensitivity/Food Allergy | <input type="checkbox"/> Digestive Disturbance                                    |
| <input type="checkbox"/> Disaccharidase Deficiencies           | <input type="checkbox"/> Renal Dysfunction                     | <input type="checkbox"/> Inadequate Nutrient Intake                               |
| <input type="checkbox"/> Fat Intolerance/Malabsorption         | <input type="checkbox"/> Dehydration                           | <input type="checkbox"/> Routine Feeding/Normal Full Term Infant                  |
| <input type="checkbox"/> Feeding Intolerance                   | <input type="checkbox"/> Protein Maldigestion                  | <input type="checkbox"/> Other: _____                                             |
| <input type="checkbox"/> Galactosemia                          | <input type="checkbox"/> Prematurity/Low Birth Weight          | _____                                                                             |
| <input type="checkbox"/> Coeliac Disease                       | <input type="checkbox"/> Short Bowel Syndrome                  | _____                                                                             |
| <input type="checkbox"/> Hypocalcemia Due to Hyperphosphatemia | <input type="checkbox"/> Spit Up/Uncomplicated GER             | _____                                                                             |
| <input type="checkbox"/> Inborn Errors of Metabolism           |                                                                |                                                                                   |

**Product Form:**  Powder  Concentrate  Ready-To-Use

**Recommended Formula:**

- |                                                       |                                                    |                                                          |
|-------------------------------------------------------|----------------------------------------------------|----------------------------------------------------------|
| <input type="checkbox"/> Similac® Alimentum®          | <input type="checkbox"/> Similac Sensitive® RS     | <input type="checkbox"/> Elecare® DHA&ARA†               |
| <input type="checkbox"/> Similac® NeoSure®            | <input type="checkbox"/> Similac® Isomil® Advance® | <input type="checkbox"/> Similac® Go & Grow™ EarlyShield |
| <input type="checkbox"/> PediaSure®                   | <input type="checkbox"/> Similac Isomil® DF        | <input type="checkbox"/> Similac® Go & Grow™ Soy Formula |
| <input type="checkbox"/> Similac Advance EarlyShield™ | <input type="checkbox"/> Elecare®†                 | <input type="checkbox"/> Ensure®                         |
| <input type="checkbox"/> Similac Sensitive®           | <input type="checkbox"/> Elecare® Vanilla†         | <input type="checkbox"/> Other: _____                    |

**Recommended Duration:**  1 Month  3 Months  6 Months  1 Year **Prescribed amount per day:** \_\_\_\_\_oz/day

**Additional supplemental foods or restrictions in addition to the prescribed WIC\* formula/medical food listed above.**

WIC* Participant Category	WIC* Supplemental Foods Available	Do Not Give	Restrictions/Comments
Infants (6-12 months)	<input type="checkbox"/> Infant Cereal <input type="checkbox"/> Infant food Vegetables/Fruit		
Children and Women	<input type="checkbox"/> Milk <input type="checkbox"/> Cheese <input type="checkbox"/> Cereal <input type="checkbox"/> Juice <input type="checkbox"/> Eggs <input type="checkbox"/> Vegetables/Fruits <input type="checkbox"/> Whole Wheat Bread <input type="checkbox"/> Beans <input type="checkbox"/> Peanut Butter <input type="checkbox"/> Canned Fish§		

Prescriber Name \_\_\_\_\_ Prescriber Signature \_\_\_\_\_

Prescriber Phone ( \_\_\_\_\_ ) \_\_\_\_\_ Fax ( \_\_\_\_\_ ) \_\_\_\_\_ Date \_\_\_\_\_

Reason(s) Formula is required

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Instructions for Preparations and Use

\_\_\_\_\_

\_\_\_\_\_

**Instructions for Women, Infants and Children Administrator:**

1. Circle the recommended product. 2. Tear off sheet. Give to patient as a visual reminder.

**This form provides information required by many state Women, Infants and Children\* Programs**