Medical Documentation Form

WIC-Eligible Nutritionals and Therapeutic Formula

Idaho WIC's current standard contract formulas are Similac Advance, Similac Soy Isomil, Similac Sensitive, and Similac Total Comfort. Medicaid is the first payer for therapeutic formulas and nutritionals. **If WIC is covering the formula, please complete this form for WIC authorization and return the completed form to the patient's WIC clinic.**

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SECTION 1 – PATIENT INFORMATION — TO BE COMPLETED FOR ALL ORDERS

Patient name (First/MI/Last):_____ **Date of Birth**:_____

Caregiver name (First/MI/Last):_____ **Caregiver phone #:**_____

OPTIONAL: Measurement date: _____

Height/Length: _____Inches. **-or-** _____ Meters.
Weight: _____Lbs. _____Oz. **-or-** _____ Kg. _____Grams.
Hemoglobin level _____

SECTION 2 — THERAPEUTIC FORMULA/NUTRITIONALS - SECTIONS A and B: MUST BE COMPLETED BY A HEALTH CARE PROVIDER.

This documentation is federally required to ensure the patient under your care has a medical condition/diagnosis that dictates the use of therapeutic formula/nutritional or requires changes to the WIC supplemental food package.

A. Therapeutic Formula/Nutritional: *(One form may identify more than one product. See the* formula handbook *healthandwelfare.idaho.gov/providers/wic/wic-partners for all allowable products.)*

- **Infant product(s):**_____
- **Toddler Nutritional Drink(s):**_____
- **Adult Nutritional Drink(s):**_____

B. Amount: ☐ Allow up the maximum **-or-** ☐ _____ ounces/day

C. Form (optional): check box if Ready-to-Feed (RTF) is medically needed and indicate **the reason.**
☐ **RTF Reason:**_____

D. If children 2-4 years and adults need whole milk in addition to the formula/nutritional drink check here (optional):
☐ Whole milk (*Normal milk issuance for these ages is low-fat 1% or skim milk*.)

SECTION 3 — LENGTH OF NEED: MUST BE COMPLETED BY A HEALTH CARE PROVIDER

☐ **1 month** ☐ **3 months** ☐ **6 months** ☐ **12 months (maximum)** ☐ **Other (Specify):**_____

Over

SECTION 4 — DIAGNOSIS(ES): MUST BE COMPLETED BY A HEALTH CARE PROVIDER. Choose all that apply and specify as applicable.

- ☐ Preterm or early term birth (≤ 38 weeks)
- ☐ Underweight or at risk for underweight (infants and children)
- ☐ Pregnant: low maternal weight gain
- ☐ High weight for length (infants and children less than 24 months)
- ☐ Upper gastrointestinal disorder
- ☐ Lower gastrointestinal disorder
- ☐ Low birth weight (≤ 5.5 lbs)
- ☐ Failure to thrive
- ☐ BMI less than 18.5 (women)
- ☐ Breastfeeding complications
- ☐ Food allergy **(Specify)**:_____
- ☐ Developmental, sensory or motor disabilities interfering with the ability to eat (dysphagia)
- ☐ Other medical condition(s) (**Specify**):_____

SECTION 5 — WIC SUPPLEMENTAL FOODS (OPTIONAL): As applicable, the patient will receive WIC foods in addition to the formula/nutritional prescribed. Please indicate the foods (if any) from the list below that are **NOT** appropriate based on the patient's diagnosis.

Do NOT Give

☐ Cow milk ☐ Soy milk ☐ Goat milk ☐ Yogurt ☐ Juice ☐ Cheese ☐ Tofu ☐ Eggs
☐ Beans ☐ Fruits/veggies ☐ Fish ☐ Cereal ☐ Peanut butter ☐ Whole grains

A. Children 1-4 years and Adults (as applicable):

☐ **WIC Dietitian** to determine foods- If selected, the WIC RD will determine appropriate issuance, prescribed amount, and length of time needed for WIC foods based on the patient's qualifying condition(s).
☐ No foods ☐ Infant cereal instead of breakfast cereal
☐ Infant purees instead of fruits/veggies at ☐ 50% ☐ 100% -**or**- ☐ Other (**Specify**):_____ of the allowed amount (formula/nutritional drink must be prescribed in Section 2A to receive infant purees).
☐ No food restrictions

B. Infants 6-11 Months (as applicable): Check applicable box if infants 6-11 M are not developmentally ready for infant foods and provide **Reason:**_____
☐ No foods- Give additional formula: ☐ Continue current formula -**or**- ☐ Select new formula (**Specify**):_____
☐ **WIC Dietitian** to determine foods (If selected, current formula ordered will continue).
☐ No infant cereal ☐ No infant fruits/veggies ☐ No fruits/veggies
☐ No food restrictions

C. Children 12-23 month need (as applicable): (*Normal milk issuance for this age is whole milk*.)

☐ Reduced fat (2%) milk for concerns with or trending towards overweight

Special instructions/comments:_____

Health Care Provider's Name:_____ ☐ MD ☐ DO ☐ PA ☐ NP ☐ CNM ☐ ANLC

Health Care Provider's Signature:_____ **Date:**_____

Fax:_____ **Phone:**_____ **Location:**_____

WIC USE ONLY	RD review:	**Date**:	WIC Clinic:	Fax #:	WIC Pt ID #:

IDAHO DEPARTMENT OF HEALTH & WELFARE
DIVISION OF PUBLIC HEALTH