Nevada WIC Medical Documentation Form

Medical documentation is required for the NV WIC program to approve special formula and nutritionals for participants. Approval is based on NV WIC program policy and procedure and USDA federal regulations. For more information go to: www.nevadawic.org/healthcare-providers/resources-for-health-care-providers/

SECTION I: PARTICIPANT INFORMATION

Participant Name: _____ Date of Birth (DOB): _____

Parent/Guardian Name:_____ Phone: _____

SECTION II: SPECIAL FORMULA/NUTRITIONALS AND SUPPLEMENTAL FOODS

Part A and B: Must be completed by a health care provider.
Part C: The health care provider can check the box below, indicating the WIC Nutritionist can determine appropriate issuance, prescribed amount, and length of time needed for WIC foods based on the patient's qualifying condition(s).

Part A) Qualifying Medical Condition

□ Premature ≤ 37 weeks gestation (P070.3)
□ Failure to thrive (R62.51)
□ Extremely low birth weight newborn (P07.00)
□ Severe food allergy (specify):
_____
□ Metabolic disorder/Inborn errors of metabolism (specify) _____
□ Malabsorption syndromes/GI disorders (specify):
_____

*Non-specific symptoms such as milk/formula intolerance, fussiness, colic, spitting up, gas, constipation or picky eating are **not** considered acceptable medical diagnoses/conditions for special formula and will not be approved. WIC **cannot** provide special formula to enhance nutrient intake or manage body weight without an underlying medical condition.*

□ Other medical condition that impairs nutrition status (specify):
_____

Part B) Special Formula

Formula requested: _____ □ Powdered □ Concentrate □ RTF

Prescribed ounces/day: _____ ***OR*** □ Max allowed **Duration:** □ 3 months □ 6 months □ Until 12 months old

Part C) Supplemental Foods

□ I authorize the WIC Nutritionist to determine appropriate issuance of supplemental foods.
□ I **DO NOT** authorize the WIC Nutritionist to determine appropriate issuance of foods. Select all that apply:

<u>Infants 6-12 months</u>

□ Formula **ONLY**. No infant foods and increased amount of formula due to inability or delay in consuming solids.

□ **OMIT** – foods checked here need to be removed from food package:
□ Infant cereal
□ Infant fruits and vegetables

<u>Child/Woman</u>

□ Provide low-fat milk for child <2 yr **OR** whole milk for woman/child ≥ 2 yrs (medical diagnosis required above)

□ Provide **baby foods** due to medical condition.

□ **Do not provide foods**. Medical formula only.

□ **OMIT** – Foods checked below need to be removed from participants food package:
□ Eggs □ Juice □ Peanut Butter □ Cheese □ Beans □ Cereal □ Milk
□ Yogurt □ Whole Grains □ Fruits/Veggies

SECTION III: HEALTH CARE PROVIDER INFORMATION (May be printed or stamped. Original signature required.)

Providers Name (please print):
_____
Providers signature: Date:
_____ _____

This institution is an equal opportunity provider.

Medical Office: _____
Address:_____
_____
Phone:_____
Fax: _____