



# ITCA WIC SPECIAL FORMULA AUTHORIZATION FORM FOR PREMATURE AND MEDICALLY FRAGILE INFANTS

<b>WIC Staff Name:</b>		<b>WIC Phone Number:</b>	
<b>A. Client Information:</b>			
Client Name:		Client DOB:	
<p>The above infant has been identified by the WIC staff as being premature and/or medically fragile. Since powder formulas are not sterile, they should only be fed to these infants if directed and supervised by a doctor. WIC issues a concentrate contract formula to these infants if no other authorization by the doctor is received. WIC encourages the authorization of powder or concentrate formula when medically appropriate, since it lowers costs and enables WIC to serve more clients. Please complete the information below so WIC is able to provide the appropriate formula.</p>			
<b>B. Current Formula Request:</b>			
<i>Please choose WIC contract formulas whenever possible.</i>			
<b>Routine Contract Formulas:</b> <input type="checkbox"/> Similac® Advance® <input type="checkbox"/> Gerber® Good Start® Soy			
<b>Other Contract Formulas:</b> <input type="checkbox"/> Similac for Spit-Up® <input type="checkbox"/> Similac Sensitive® <input type="checkbox"/> Similac Total Comfort™			
<b>Special Formulas :</b> <input type="checkbox"/> Enfamil® EnfaCare®, 22 kcal <input type="checkbox"/> Similac Expert Care® NeoSure®, 22 kcal <input type="checkbox"/> Similac® Special Care® With Iron, 24 kcal (RTF only) <input type="checkbox"/> Enfamil® Premature, 24 kcal (RTF only)			
<u>Other Special Formula Requested:</u>			
<b>C. Form of Formula to Be Issued:</b>			
<input type="checkbox"/> Powder <input type="checkbox"/> Concentrate <input type="checkbox"/> Ready-to-feed			
<b>D. Amount of Formula Requested Per Day:</b>			
# of ounces _____ <input type="checkbox"/> Oral <input type="checkbox"/> Tube Feeding			
<b>E. Medical Reason for Special Formula Request:</b>			
Must be a specific medical diagnosis; weight loss, diarrhea, constipation, vomiting and rashes are not valid medical reasons.			
Specific Medical Diagnosis:			
<b>F. Food Request:</b>			
For infants 6-11 months: <input type="checkbox"/> Default to WIC Registered Dietitian (RD) to select WIC appropriate foods <input type="checkbox"/> No foods are appropriate for the client <input type="checkbox"/> Baby Food Fruit/Vegetables <input type="checkbox"/> Fresh Fruit/Vegetables (for infants 9-11 months) <input type="checkbox"/> Infant Cereal			
<b>G. Length of Time Requested:</b>			
<input type="checkbox"/> 1 month <input type="checkbox"/> 2 months <input type="checkbox"/> 3 months <input type="checkbox"/> 4 months <input type="checkbox"/> 5 months <input type="checkbox"/> 6 months			
<b>H. Health Care Provider Information:</b>			
Provider Name:		Date:	
Medical/Office Name and Address:			
Provider Signature:		Phone Number:	
<b>WIC Registered Dietitian Approval</b>			
<input type="checkbox"/> Approved <input type="checkbox"/> Not Approved			
Length of Authorization: From: _____ To: _____			
Comments:			
R.D. Signature:		Date:	



# ITCA WIC SPECIAL FORMULA AUTHORIZATION FORM CHILDREN, WOMEN & HEALTHY INFANTS

<b>WIC Staff Name:</b>		<b>WIC Phone Number:</b>	
<b>A. Client Information:</b>			
Client Name:		Client DOB:	
<b>B. Formulas Previously Tried:</b>			
Contract Formulas: <input type="checkbox"/> Similac® Advance® <input type="checkbox"/> Gerber® Good Start® Soy			
<u>Other Formula:</u>			
<b>C. Current Formula Request:</b>			
<i>Please choose WIC contract formulas whenever possible.</i>			
Routine Contract Formulas: <input type="checkbox"/> Similac® Advance® <input type="checkbox"/> Gerber® Good Start® Soy			
Other Contract Formulas: <input type="checkbox"/> Similac for Spit-Up® <input type="checkbox"/> Similac Sensitive® <input type="checkbox"/> Similac Total Comfort™ <input type="checkbox"/> Gerber® Graduates® Soy			
<u>Other Formula Requested:</u>			
<b>D. Amount of Formula Requested Per Day:</b>			
# of ounces _____ <input type="checkbox"/> Oral <input type="checkbox"/> Tube Feeding			
<b>E. Medical Reason for Special Formula Request:</b>			
Must be a specific medical diagnosis; weight loss, diarrhea, constipation, vomiting and rashes are not valid medical reasons.			
<u>Specific Medical Diagnosis:</u>			
<b>F. Food Request:</b>			
<input type="checkbox"/> Default to WIC Registered Dietitian (RD) to select appropriate WIC foods.			
<input type="checkbox"/> All foods: Infants 6 months and older receive baby food fruit/vegetables and infant cereal; infants 9 months and older may receive fresh fruits and vegetables; women and children receive items below.			
<input type="checkbox"/> No foods: Foods are not appropriate, provide only formula			
<input type="checkbox"/> Provide only these selected foods: <input type="checkbox"/> Milk (low fat) <input type="checkbox"/> Whole Milk <input type="checkbox"/> Soy Milk <input type="checkbox"/> Tofu <input type="checkbox"/> Cheese <input type="checkbox"/> Yogurt <input type="checkbox"/> Beans <input type="checkbox"/> Peanut Butter <input type="checkbox"/> Eggs <input type="checkbox"/> Breakfast Cereal <input type="checkbox"/> Whole Grains <input type="checkbox"/> Fruit/Vegetables <input type="checkbox"/> Juice <input type="checkbox"/> Infant Fruit/Vegetables <input type="checkbox"/> Infant Cereal			
<b>G. Length of Time Requested:</b>			
<input type="checkbox"/> 1 month <input type="checkbox"/> 2 months <input type="checkbox"/> 3 months <input type="checkbox"/> 4 months <input type="checkbox"/> 5 months <input type="checkbox"/> 6 months			
<b>H. Health Care Provider Information:</b>			
Provider Name:		Date:	
Medical/Office Name and Address:			
Provider Signature:		Phone Number:	
<b>WIC Registered Dietitian Approval</b>			
<input type="checkbox"/> Approved <input type="checkbox"/> Not Approved			
Length of Authorization: From:		To:	
Comments:			
R.D. Signature:		Date:	



