

Sherburne County Health & Human Services - WIC Program  
 Phone: 763-765-4116 or 800-433-5239 FAX: 763-765-4154  
 Email: WIC@co.sherburne.mn.us



## Minnesota WIC Program Request for Medical Formula

The WIC Program requires a medical diagnosis to provide a medical formula/food and/or to change the WIC food package.  
 Please COMPLETE this form. All requests are subject to WIC approval.

### A. Patient Information

Patient's Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Parent/Caregiver's Name: \_\_\_\_\_

### B. Medical Formula

Formula Requested: \_\_\_\_\_

Amount Needed per Day: \_\_\_\_\_

If not specified, up to (but no more than), WIC maximum allowable may be provided. Maximum allowed might not meet patient's full need.

Preparation/Feeding Instructions: \_\_\_\_\_

Standard preparation, unless otherwise specified.

Intended Length of Use:    1 month    2 months    3 months    4 months    5 months    6 months

NOTE: If no length specified, may provide up to 6 months. All prescriptions reevaluated every 6 months.

### C. Qualifying Medical Reason (check all that apply)

Prematurity    Low Birth Weight    Gastrointestinal Disorders    GERD/Reflux    Severe Food Allergies

Failure to Thrive – *specify underlying medical condition:* \_\_\_\_\_

Other Condition (describe): \_\_\_\_\_

### D. WIC Supplemental Foods

Standard Food Package (If no changes are specified, standard foods will be provided.)

**Infants** (6-12 months) will receive infant cereal and infant and/or fresh fruits/vegetables

**Children** (12-60 months) and **Women** will receive milk, cheese, juice, fruits/vegetables, whole grains, eggs, legumes, peanut butter, cereal, (canned fish – breastfeeding women only)

Provide age appropriate WIC foods. **Exceptions (specify):** \_\_\_\_\_

**Omit all** supplemental WIC foods, and provide medical formula only.

For child (age 1-4) receiving medical formula, provide infant fruits/vegetables.

Provide whole milk/yogurt. Only patients receiving medical formula and who need additional calories may receive whole milk/yogurt.

### E. Health Care Provider Information

Signature of Health Care Provider: \_\_\_\_\_

Date: \_\_\_\_\_

Provider's Name: *please print* \_\_\_\_\_

MD    NP    PA    CNM    DO

Medical Office: \_\_\_\_\_

Phone #: \_\_\_\_\_

Fax #: \_\_\_\_\_

### WIC Use Only

(Local Agency Information)