

Ohio WIC Prescribed Formula and Food Request - Women, Infants, and Children

Please complete this *Ohio WIC Prescribed Formula and Food Request* form in full.

Patient's name (please print)	Date of birth
Caregiver's name (please print)	Phone

Parts 1-5 REQUIRED FOR APPROVAL - Please complete the following information:

1. Amount of infant/child/adult formula to be provided per **DAY**: _____
 2. Intended length of use (**must not exceed 6 months at a time**): _____
 3. ICD-9 code: _____ and Medical diagnosis (please print): _____
- Describe condition or symptoms causing need for specialized formula: _____

4. Prescribed Formulas:

Infants and Children

WIC receives a rebate for Similac Advance and Similac Isomil Advance. Rebates help WIC provide services to more participants. A trial with **either** of these formulas is required **prior** to ordering any of the formulas listed in the box below.

Please indicate if the infant has tried **either** Similac Advance or Similac Isomil Advance formulas: Yes No
 If no, please explain: _____ Is re-lactation an option? Yes No

<input type="checkbox"/> EleCare Unflavored	<input type="checkbox"/> Enfamil Nutramigen Lipil w/ Enflora LGG (powder only)	<input type="checkbox"/> Neocate Infant with DHA & ARA
<input type="checkbox"/> EleCare Unflavored with DHA & ARA	<input type="checkbox"/> Enfamil Nutramigen Lipil (liq conc & RTF only)	<input type="checkbox"/> Similac Alimentum
<input type="checkbox"/> Enfamil EnfaCare Lipil (≤ 12 mo corrected age)	<input type="checkbox"/> Enfamil Pregestimil Lipil	<input type="checkbox"/> Similac Sensitive (≤ 12 mo corrected age)
<input type="checkbox"/> Enfamil Enfaport Lipil	<input type="checkbox"/> Neocate Infant	<input type="checkbox"/> Similac NeoSure (≤ 12 mo corrected age)
		<input type="checkbox"/> Similac PM 60/40

Infant Foods: Indicate which infant foods listed below are contraindicated or require restrictions.

<input type="checkbox"/> Infant Cereal	<input type="checkbox"/> Fruits (baby food textures)	<input type="checkbox"/> Vegetables (baby food textures)	<input type="checkbox"/> Do not provide any of the infant WIC foods listed
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Children Only

<input type="checkbox"/> Boost Kid Essentials 1.0 Cal	<input type="checkbox"/> Neocate One +	<input type="checkbox"/> Peptamen Junior with Fiber
<input type="checkbox"/> Boost Kid Essentials 1.5 Cal	<input type="checkbox"/> Nutren Junior	<input type="checkbox"/> Peptamen Junior 1.5 Cal
<input type="checkbox"/> Boost Kid Essentials with Fiber 1.5 Cal	<input type="checkbox"/> Nutren Junior with Fiber	<input type="checkbox"/> Portagen
<input type="checkbox"/> Bright Beginnings Soy Pediatric Drink	<input type="checkbox"/> PediaSure	<input type="checkbox"/> Similac Advance (≤ 12 mo corrected age)
<input type="checkbox"/> Compleat Pediatric	<input type="checkbox"/> PediaSure with Fiber	<input type="checkbox"/> Similac Isomil Advance
<input type="checkbox"/> E028 Splash	<input type="checkbox"/> PediaSure Enteral	<input type="checkbox"/> Super Soluble Duocal
<input type="checkbox"/> Monogen	<input type="checkbox"/> PediaSure with Fiber Enteral	<input type="checkbox"/> Vital Jr.
<input type="checkbox"/> Neocate Junior	<input type="checkbox"/> Peptamen Junior	<input type="checkbox"/> Vivonex Pediatric

Adult

<input type="checkbox"/> A-Soy	<input type="checkbox"/> Ensure	<input type="checkbox"/> Portagen	<input type="checkbox"/> Super Soluble Duocal
<input type="checkbox"/> Boost	<input type="checkbox"/> Monogen	<input type="checkbox"/> Resource Breeze	

For PKU and Metabolic Needs: WIC collaborates with the Ohio Metabolic Formula Program which supplies certain PKU and metabolic formulas prescribed by an Ohio Department of Health (ODH) approved metabolic service provider. A separate form must be completed. Please contact your WIC office for more information.

5. WIC Foods:

Participants on Prescribed Formulas may receive the following foods offered by WIC.

Please indicate the appropriateness of the following foods to accompany the prescribed formula.

WIC Foods That May Be Provided (12 Months and Older, Adults)

Check this box to give authority to the WIC health professional (RD/LD, RN or DTR) to prescribe the foods listed below based upon the complete nutritional assessment.

Are there any contraindications or restrictions for any of these foods?

No Yes, specify:

- | | |
|---|---|
| <input type="checkbox"/> Milk | <input type="checkbox"/> Beans, dried peas and legumes |
| <input type="checkbox"/> Juice | <input type="checkbox"/> Peanut butter |
| <input type="checkbox"/> Breakfast cereal | <input type="checkbox"/> Whole grains |
| <input type="checkbox"/> Eggs | (bread, brown rice, oatmeal, corn/whole wheat tortillas) |
| <input type="checkbox"/> Fruits | <input type="checkbox"/> Fish (women only, as applicable) |
| <input type="checkbox"/> Vegetables | <input type="checkbox"/> Infant cereal (child only) |

Do not provide any of the above WIC foods

Milk Substitutions:

(Children Age 2 Years and Older & Adults)

Indicate which foods are to be **substituted** for reduced fat, low fat or skim milk for the following diagnoses: *Lactose intolerance, FTT, slow weight gain, low/under weight, or other qualifying conditions.*

- | | | |
|--|---------------------------------|---|
| <input type="checkbox"/> Whole milk | <input type="checkbox"/> Cheese | <input type="checkbox"/> Not Applicable |
| <input type="checkbox"/> Lactaid® whole milk | | |

Health Care Provider's Name (please print)	Phone
Health Care Provider's Signature	Date