

# For Infants Only (Side One)

## Texas WIC Medical Request for Formula/Food

For women and children formula/food requests, use the reverse side.

All requests are subject to WIC approval and provision based on program policy and procedure.  
Please fax the completed form to the WIC clinic or have your patient return the document to their WIC Clinic.

### Required Patient Information

Patient's Name (First, Last, MI): \_\_\_\_\_ DOB: \_\_\_\_\_  
Parent/ Caregiver's Name: \_\_\_\_\_ Phone Number: \_\_\_\_\_

### Alternate Similac WIC Formulas

Similac Advance and Good Start Soy are the formulas provided to infants on WIC. If Similac Advance is not tolerated, alternate formulas may be requested.

Check below to request an alternate WIC formula due to formula intolerance to Similac Advance or Good Start Soy:

- Similac Sensitive-for lactose sensitivity and/or colic
- Similac for Spit Up-for excessive spitting up and/or reflux
- Similac Total Comfort-for digestive issues and/or colic

Maximum allowed by federal guidelines will be provided unless a lesser amount is indicated here: Formula Amount \_\_\_\_\_ per day

Formula will be issued to 12 months of age unless a shorter time period is indicated here: Requested Length of issuance \_\_\_\_\_

A trial of Similac Advance is contraindicated due to the following severe and exceptional medical condition(s): \_\_\_\_\_

### Other Formulas

Name of Formula: \_\_\_\_\_

Qualifying Condition/Diagnosis: \_\_\_\_\_

Requested length of issuance:

3 months     6 months     Other: \_\_\_\_\_

Maximum allowed by federal guidelines will be provided unless a lesser amount is indicated below:

Formula Amount \_\_\_\_\_ per day

Note: Non-WIC standard formulas are not provided for formula intolerance symptoms such as spit-up, colic, constipation or gas.

A retrial of WIC contract formula will occur up to a maximum of 3 months after the non-WIC formula has been provided. (Does not apply to therapeutic formulas.) If a retrial is medically contraindicated, please state reason here:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Date of measurements: \_\_\_\_\_

Length/Height: \_\_\_\_\_ Weight: \_\_\_\_\_ If Premature: Birth Weight: \_\_\_\_\_ Weeks Gestation: \_\_\_\_\_

### WIC Supplemental Foods (at 6 months of age)

Unless indicated below, all supplemental foods will be provided. The RD/Nutritionist can determine the appropriate supplemental foods and amounts if left blank.

\_\_\_ Formula only (no foods and increased amount of formula past 6 months of age due to inability or delay in consuming solids).

\_\_\_ Omit –The foods indicated here need to be omitted from my patients' WIC food Package:     Infant Cereal     Baby Foods

### Health Care provider information (signature/stamp and all information below required to process request)

Signature/Stamp of Health Care Provider (MD, DO, PA, NP): \_\_\_\_\_ Date \_\_\_\_\_

Provider's Name (please print) \_\_\_\_\_ Medical Office/Clinic \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

### For WIC Use Only

WIC Clinic: \_\_\_\_\_ Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

**Women and Children Only (Side Two)**  
**Texas WIC Medical Request for Formula/Food**

**For infant formula/food requests use the reverse side.**

All requests are subject to WIC approval and provision based on program policy and procedure.  
Please fax the completed form to the WIC clinic or have your patient return the document to their WIC Clinic.

**Required Patient Information**

Patient's Name (First, Last, MI): \_\_\_\_\_ DOB: \_\_\_\_\_

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

Name of Formula: \_\_\_\_\_

Qualifying Condition/Diagnosis: \_\_\_\_\_

Requested length of issuance:

3 months       6 months       Other: \_\_\_\_\_

Maximum allowed by federal guidelines will be provided unless a lesser amount is indicated below:

Formula Amount \_\_\_\_\_ per day

Date of measurements: \_\_\_\_\_

Length/Height: \_\_\_\_\_ Weight: \_\_\_\_\_ If premature: Birth Weight: \_\_\_\_\_ Weeks Gestation: \_\_\_\_\_

**WIC Supplemental Foods**

Unless indicated below, all supplemental foods will be provided. The RD/Nutritionist can determine the appropriate supplemental foods and amounts if left blank.

None – Do not provide supplemental foods at this time; issue medical formula only

Omit—The foods indicated below need to be omitted from my patient's WIC food package:

Milk     Eggs     Juice     Peanut Butter     Cheese     Whole Grains     Cereal     Beans     Fruits and Vegetables

Provide baby foods due to medical condition and inability to consume table foods

**Health Care provider information (signature/stamp and all information below required to process request).**

Signature/Stamp of Health Care Provider (MD, DO, PA, NP): \_\_\_\_\_ Date \_\_\_\_\_

Provider's Name (please print) \_\_\_\_\_ Medical Office/Clinic \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

**For WIC Use Only**

WIC Clinic: \_\_\_\_\_ Phone: \_\_\_\_\_ Fax: \_\_\_\_\_



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