

MICHIGAN WIC SPECIAL FORMULA/FOOD REQUEST

Michigan Department of Health and Human Services

Client Name	Date of Birth	Parent/Guardian Name			
Please specify the underlying qualifying condition below. Conditions such as rash, non-specific intolerance, underweight fussiness, colic, spitting-up, vomiting, gas and constipation will NOT be considered indications for a special formula.					
1. QUALIFYING MEDICAL CONDITION(S): <input type="checkbox"/> Premature birth < 37 weeks gestation <input type="checkbox"/> Failure to thrive <input type="checkbox"/> Severe food allergies (specify) _____ <input type="checkbox"/> Immune system disorder (specify) _____ <input type="checkbox"/> Metabolic disorder/inborn errors of metabolism (specify) _____ <input type="checkbox"/> Medical condition that impairs nutrition status (specify) _____ <input type="checkbox"/> Gastrointestinal disorder/malabsorption syndromes (specify) _____					
2. FORMULA: <u>PurAmino</u> Select Amount Requested: _____ Ounces/day or <input type="checkbox"/> Maximum Allowable* <small>*Up to the WIC maximum allowable may be provided. Maximum allowable may not meet patient's full need. A list of Michigan Authorized Formulas is available at: www.michigan.gov/wic. click on Medical Providers</small>					
3. SUPPLEMENTAL WIC FOODS: (<u>CHECK ONE</u>; MUST BE COMPLETED FOR <u>ALL</u> FORMULA REQUESTS) <input type="checkbox"/> All (issue all allowed age appropriate WIC Foods starting at six months) <input type="checkbox"/> Restriction (check foods to be OMITTED): <table style="width: 100%; border: none;"> <tr> <td style="width: 33%; vertical-align: top;"> Infant (6-12 months) <input type="checkbox"/> All (issue formula only) <input type="checkbox"/> Infant cereal <input type="checkbox"/> Infant fruits/vegetables </td> <td style="width: 33%; vertical-align: top;"> Child (1-5 years) and Woman <input type="checkbox"/> All (issue formula only) <input type="checkbox"/> Milk <input type="checkbox"/> Yogurt <input type="checkbox"/> Cheese <input type="checkbox"/> Eggs <input type="checkbox"/> Legumes <input type="checkbox"/> Peanut butter <input type="checkbox"/> Breakfast cereal <input type="checkbox"/> Bread, rice, tortilla, oatmeal, pasta <input type="checkbox"/> Fresh fruits/vegetables <input type="checkbox"/> 100% fruit/vegetable juice <input type="checkbox"/> Canned fish (women only) </td> <td style="width: 33%; vertical-align: top;"> Special Instructions/Comments: _____ _____ _____ _____ _____ _____ </td> </tr> </table>			Infant (6-12 months) <input type="checkbox"/> All (issue formula only) <input type="checkbox"/> Infant cereal <input type="checkbox"/> Infant fruits/vegetables	Child (1-5 years) and Woman <input type="checkbox"/> All (issue formula only) <input type="checkbox"/> Milk <input type="checkbox"/> Yogurt <input type="checkbox"/> Cheese <input type="checkbox"/> Eggs <input type="checkbox"/> Legumes <input type="checkbox"/> Peanut butter <input type="checkbox"/> Breakfast cereal <input type="checkbox"/> Bread, rice, tortilla, oatmeal, pasta <input type="checkbox"/> Fresh fruits/vegetables <input type="checkbox"/> 100% fruit/vegetable juice <input type="checkbox"/> Canned fish (women only)	Special Instructions/Comments: _____ _____ _____ _____ _____ _____
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4. MILK SUBSTITUTIONS (optional): Medical Reason for Milkfat Change: _____ <input type="checkbox"/> 2% milk (in place of ≤ 1% milkfat, woman/child ≥ 2 years; or whole milk, child 12-23 months). Honored only if medically indicated. <input type="checkbox"/> Whole milk (in place of ≤ 1% milkfat, woman/child ≥ 2 years). Honored only if medically indicated formula prescribed above. <input type="checkbox"/> Soy Beverage in place of milk for child: <input type="checkbox"/> Milk allergy <input type="checkbox"/> Lactose intolerance <input type="checkbox"/> Vegetarian/Vegan diet <input type="checkbox"/> Cultural practice <input type="checkbox"/> Other _____					
5. DURATION: <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 (maximum approval)					
Medical Provider Name		WIC Use Only Client # (Optional)			
Address		Approved Through (Optional)			
Phone Number	Fax	Reason (if denied)			
Signature	Date	Signature (if denied) Date			

WIC CLINIC: _____ Phone: _____ Fax: _____

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