

(Local agency information)

# 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: Nutramigen with Enflora LGG Toddler

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

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