



## NEVADA WIC MEDICAL DOCUMENTATION FORM

Participant's Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

Parent/Caregiver First & Last Name \_\_\_\_\_

**Standard Formulas** – Nevada WIC provides the following standard formula: Similac Advance and Gerber Good Start Soy

**Unapproved Formulas** – Nevada WIC **cannot** provide the following formula: Enfamil Prosobee, Enfamil Newborn, Enfamil Infant, Enfamil A.R., Gentlease, Reguline, Similac Soy Isomil, Gerber Good Start Gentle Soothe

**Indicate qualifying medical diagnosis (es) to justify request for special formula or milk change: *Non-specific symptoms such as intolerance, fussiness, colic, spitting up, gas, constipation will NOT be considered indications for a special formula.***

- |  |  |
|--|--|
| <input type="checkbox"/> Unspecified lack of expected normal physiological development in childhood (R62.50) | <input type="checkbox"/> Soy or corn allergy – Dermatitis due to ingested food (L27.2)   |
| <input type="checkbox"/> Failure to thrive – child (R62.51)  | <input type="checkbox"/> Heart/circulatory (390-459)                                     |
| <input type="checkbox"/> Extremely low birth weight newborn, unspecified weight (P07.00)                     | <input type="checkbox"/> Gastroesophageal reflux (K21.9)                                 |
| <input type="checkbox"/> Cerebral Palsy, unspecified (G80.9)   | <input type="checkbox"/> Malabsorption syndromes (K90.6)                                 |
| <input type="checkbox"/> Other medical diagnosis _____   | <input type="checkbox"/> Inborn errors of metabolism and metabolic disorders (270-279.9) |
|  | <input type="checkbox"/> Allergy to milk products (Z91.011)                              |
|  | ICD-9 _____  |

**Indicate qualifying diagnosis (es) for the following (previously standard) Formula.**

*Please check diagnosis (es) for Similac intolerance formulas*

- ☐ Similac Sensitive: Other disorders of intestinal carbohydrate absorption – Lactose Sensitivity (E74.39)
- ☐ Similac Total Comfort: Other disorders of intestinal carbohydrate absorption – Lactose Sensitivity (E74.39)
- ☐ Similac For Spit-Up: Other disorders of intestinal carbohydrate absorption – Lactose Sensitivity (E74.39); Gastro-esophageal reflux disease w/o esophagitis (K21.9)

**WIC approved special formula requested:** \_\_\_\_\_ Nutramigen with Enflora LGG

Prescribed amount per day \_\_\_\_\_ oz./per day

If your patient requires **Therapeutic Formula**, please indicate which solid foods are to be **excluded**. For example, a **child** on elemental formula or nutritional drink would typically **not** be given milk or cheese, and these foods should be checked.

**WIC supplemental foods: *(Must be completed for 6 months and older)***

- ☐ Defer all food package tailoring, including amount, time & length to a WIC Nutritionist/ Registered Dietitian
- ☐ Issue maximum allowed of age appropriate foods
- ☐ No WIC supplemental foods. Provide formula only
- ☐ Food Restrictions (Issue all but items checked below)

**Infants (6-11 months):** ☐ no infant cereal ☐ no infant fruits or vegetables

**Children & Women:** ☐ no milk ☐ no cheese ☐ no breakfast cereal ☐ no whole wheat grains  
☐ no fruits & vegetables (CVB) ☐ no beans ☐ no peanut butter  
☐ no juice ☐ no eggs ☐ no fish (fully breastfeeding women only)

**WIC issues whole milk to children 12-23 months of age – fat-free or 1% milk to women and children over 24 months**

- ☐ Substitute a fat-reduced milk for children 12-23 months of age: ☐ 2% ☐ 1% ☐ fat-free
- ☐ Substitute whole milk for women and children older than 24 months. Whole milk is **ONLY** available if they are receiving a medical formula and have a medical need for whole milk. ☐ Whole (include diagnosis above)

**Medical Documentation Valid for:** ☐ 3 months ☐ 6 months (Personal preference is not allowable)

\_\_\_\_\_  
**Physician's Signature**

\_\_\_\_\_  
**Date**

\_\_\_\_\_  
**Physician Printed Name**

\_\_\_\_\_  
**Telephone**

\_\_\_\_\_  
**Medical/Clinic Name**

\_\_\_\_\_  
**Street, City, State and Zip Code**

Children	Pregnant or Partially Breastfeeding Women	Fully Breastfeeding Women	Non Breastfeeding Post-Partum Women
910 fl. oz reconstituted formula	910 fl. oz reconstituted formula	910 fl. oz reconstituted formula	910 fl. oz reconstituted formula
16 quarts milk (1 lb cheese may be substituted for 3 qts)	22 quarts milk (1 lb cheese may be substituted for 3 qts)	24 quarts milk <b>AND</b> 1 lb cheese (Up to 2 lb cheese may be substituted at a rate of 1lb for 3 qts)	16 quarts milk (1 lb cheese may be substituted for 3 qts)
1 dozen eggs	1 dozen eggs	2 dozen eggs	1 dozen eggs
36 oz cereal	36 oz cereal	36 oz cereal	36 oz cereal
32 oz whole grain	16 oz whole grain	16 oz whole grain	N/A
18 oz peanut butter <b>OR</b> 1 lb dried peas/beans <b>OR</b> 4 14-16oz cans of beans	18 oz peanut butter <b>AND</b> 1 lb dried peas/beans <b>OR</b> 4 14-16oz cans of beans	18 oz peanut butter <b>AND</b> 1 lb dried peas/beans <b>OR</b> 4 14-16oz cans of beans	18 oz peanut butter <b>OR</b> 1 lb dried peas/beans <b>OR</b> 4 14-16oz cans of beans
2 – 64 oz juice containers	3 –11.5-12 oz concentrate juice	3 –11.5-12 oz concentrate juice	2 – 11.5-12 oz concentrate juice
\$8.00 Cash Value Benefit for fruit and vegetables	\$11.00 Cash Value Benefit for fruit and vegetables	\$11.00 Cash Value Benefit for fruit and vegetables	\$11.00 Cash Value Benefit for fruit and vegetables
		30 ounces canned fish	

Formula	Infants 0-3 months*	Infants 4-5 months*	Infants 6-11 months*	Infants 6-11 months*
Reconstituted Powder	870 fluid ounces	960 fluid ounces	696 fluid ounces	960 fluid ounces
Foods	N/A	N/A	128 oz infant fruits & veggies 24 oz infant cereal 31 – 2.5 oz jars infant meats (fully breastfed only)	*** Infants 6-11 months of age receiving medical formula <b>when solids are contraindicated</b>

**\*Formula quantities provided are less if the infant is breastfed**

### Nevada WIC Program

#### Medical Documentation for WIC Approved Special Formula and WIC Approved Foods for Infants, Children and Women

#### (Instructions for Completion)

**PURPOSE:** To use when issuing a prescription for WIC approved special formula and WIC approved foods.

**EXPLANATION AND DEFINITION:** This form is completed by the physician or health care professional licensed to write medical prescriptions under State Law.

#### ITEM-BY-ITEM INSTRUCTIONS:

**PARTICIPANT'S NAME:** Enter name of the participant.

**DATE-OF-BIRTH:** Enter participant's birth date.

**PARENT/CAREGIVER'S FIRST AND LAST NAME(S):** Enter the parent or caregiver's first and last name(s).

**QUALIFYING MEDICAL DIAGNOSIS(ES):** Place a check (✓) beside one or more of the described medical conditions, or check (✓) "other" and enter the medical diagnosis and ICD-10 code.

**(NOTE: Symptoms such as spitting up, milk/formula intolerance, picky eater, constipation, cramps, fussiness, or gas are not considered acceptable medical diagnoses and will not be approved by WIC for issuance of a special formula.)**

**WIC SPECIAL FORMULA REQUESTED:** Enter requested WIC special formula.

**PRESCRIBED AMOUNT PER DAY:** Check "maximum amount" or enter prescribed amount per day.

**SPECIAL INSTRUCTIONS/COMMENTS:** Enter any special instructions or comments.

**LENGTH-OF-USE:** Place a check (✓) beside the time period for which the prescription is valid.

**(Special formula not to exceed 6 months. Exception: Metabolic formula prescription not to exceed 1 year)**

**SUPPLEMENTAL FOODS:** Select option for supplemental foods or select foods not allowed.

**MEDICAL DOCUMENTATION:** Place a check (✓) beside the time period for which the prescription is valid.

**PHYSICIAN'S OR ADVANCED PRACTICE REGISTERED NURSE'S SIGNATURE:** Enter signature.

**DATE:** Enter the date the prescription is being issued.

**PROVIDER'S NAME:** Print name of physician or authorized health care professional. May stamp contact information.

**MEDICAL OFFICE/CLINIC:** Enter medical office or clinic's name.

**TELEPHONE NUMBER:** Enter telephone number.

**STREET, CITY, STATE AND ZIP CODE:** Enter address of medical office or clinic.