



Rhode Island Department of Health Medical Documentation for WIC Formula and Approved WIC Foods

Infants & Children

Completion of this form is federally required to ensure that the patient under your care has a medical condition/diagnosis that requires the use of medical formula/food and/or changes to their supplemental food package.

A. Patient Information (Complete All)	
Patient's Name:	DOB:
Parent/Caregiver's Name:	
Medical Diagnosis/Qualifying Condition(s): _____ _____	
Including ICD-9 code: _____ _____	

B. Medical Formula/Medical Food	
Name of medical formula/medical food:	
Prescribed amount: <input type="checkbox"/> Maximum allowable OR <input type="checkbox"/> _____ oz per day	
Requested length of issuance: <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6 Months	

C. Supplemental Foods		
**In addition, supplemental foods will be issued for participants over 6 months of age, unless contraindicated. Please review and select the issuance appropriate for your patient:		
WIC foods allowed – Infants 6-12 months (Please select all that apply)		
<input type="checkbox"/> Baby food fruits & vegetables		
<input type="checkbox"/> Infant cereal		
<input type="checkbox"/> Infant unable to take other foods at this time		
WIC foods allowed – Children (Please select all that apply)		
<input type="checkbox"/> Juice	<input type="checkbox"/> Peanut Butter	<input type="checkbox"/> Fruits & Vegetables
<input type="checkbox"/> Eggs	<input type="checkbox"/> Cereal	<input type="checkbox"/> Cheese
<input type="checkbox"/> Legumes	<input type="checkbox"/> Whole grain bread/other whole grains	<input type="checkbox"/> Milk**
** <input type="checkbox"/> Issue whole milk: WIC provides 1% low fat milk for all children ≥ 2 years. Only participants who need additional calories may receive whole milk.		

D. Health Care Provider Information (Complete all)		
Provider's Name (please print):		
Signature of health care provider:		
Medical office/clinic:		
Phone:	Fax#:	Date: