



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

Pregnant, Breastfeeding and Postpartum Women

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:
Medical Diagnosis/Qualifying Condition(s): _____ _____	
Including ICD-9 code: _____ _____	
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	

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	

C. Supplemental Foods	
**In addition, supplemental foods will be issued for participants unless contraindicated. Please review and select the issuance appropriate for your patient:	
WIC foods allowed (Please select all that apply):	
<input type="checkbox"/> Juice	<input type="checkbox"/> Peanut Butter
<input type="checkbox"/> Eggs	<input type="checkbox"/> Cereal
<input type="checkbox"/> Legumes	<input type="checkbox"/> Whole grain bread/other whole grains
<input type="checkbox"/> Canned Fish*	<input type="checkbox"/> Fruits & Vegetables
	<input type="checkbox"/> Cheese
	<input type="checkbox"/> Milk**
*Fully breastfeeding women are the only category eligible to received canned fish.	
** <input type="checkbox"/> Issue whole milk: WIC provides 1% low fat milk for all women. 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: _____