D.C. WIC Medical Documentation & Referral Form for WOMEN, INFANTS & CHILDREN

This form is used for referring clients to WIC or special dietary requests. Complete one for each participant.

Patient's Name _____ Date of Birth_____

Address _____ City_____ Zip Code_____

Parent / Caregiver's Name _____ Telephone_____

Medical Data:

DATE MEASURED	LENGTH / HEIGHT	WEIGHT	DATE MEASURED	HGB MEASURED	DATE MEASURED	GLUCOSE (IF GESTATIONAL DIABETIC)	DATE MEASURED	BLOOD LEAD LEVEL

Women (pregnant, nursing, or less than six months postpartum):
Pregnant/ Estimated date of delivery: _____
Multi-fetal Gestation ❑ Yes ❑ No
Pre-pregnancy wt _____
Feeding Plan
- ❑ Fully breastfeeding
- ❑ Combination of feeding: Breast milk and formula
- ❑ Do not recommend breastfeeding due to the following medical diagnosis:

_____

Postpartum / Date pregnancy ended: _____

Infants and Children ❑ Female ❑ Male
Birth History: ❑ SGA ❑ LGA
Birth Weight_____ lb _____oz OR_____kg
Birth Length_____ inches OR _____cm
Weeks of Gestation_____
Feeding Prescription
- ❑ Fully breastfeeding
- ❑ Combination of feeding: Breast milk and formula
- ❑ Do not recommend breastfeeding due to the following medical diagnosis:

_____

If no special formula or diet is requested, stop here and sign.

Provider's Name (Please Print):

Signature:

Credential: ❑ **MD** ❑ **DO** ❑ **PA** ❑ **CNP** ❑ **CNM** (Certified Nurse Midwife)
(Please check) ❑ **RD** ❑ **LD** ❑ **RN** ❑ **LPN** ❑ **LSW**

Signature of **MD / DO / PA / CNM / CNP required if requesting special formula or dietary change**
Signature of **RD / LD / RN / LPN / LSW when providing medical data only.**
Date_____ Medical Office / Clinic: _____
Address _____
Phone Number _____ Fax Number_____

Formula/Supplement/Medical Food Request (Requires MD/DO/PA/CNP/CNM signature on back)
Formula Name:_____
Amount needed:_____ ounces per day _____ calories per ounce
Length of time: ❑ 3 months ❑ 6 months ❑ Other _____
Additional instructions:

Patients will receive supplemental foods (appropriate to their age and participant category) in addition for formula indicated Prescription renewal is required periodically based on age, medical condition and nutrition assessment.

Other infant formula(s) tried so far (include basic infant formula if used)			
Name	**Date Started**	**Date Ended**	**Results**

❑ **Medically contraindicated for infant to try formula(s) other than the one prescribed.**

A special request formula for infants will be considered only when Similac Advance or Gerber Good Start Soy are inappropriate due to a documented medical reason.
WIC cannot provide the following formulas, even with medical documentation:
- Any low iron formula
- Enfamil Premium of Similac Isomil
- Premium Newborn for supplementation
- Enfamil Prosobee

The following are inappropriate reasons to prescribe a special formula:
Fussiness / spitting up / gas / constipation / lactose intolerance / a non-specific formula or food intolerance / participant preference / solely for the purpose of enhancing nutrient intake / managing body weight without a medical condition

Please continue and sign on back page

WIC Supplemental Foods Available	Do NOT Give	WIC Supplemental Foods Available	Do NOT Give
Infant Cereal		Vegetables / Fruits (specify below)	
Infant Food Vegetables/Fruits		Eggs	
Infant Meat *		Whole Wheat Bread	
Milk		Corn Tortillas	
Whole Oats		Brown Rice	
Cheese		Dried Beans, Peas, Lentils	
Cereal		Peanut Butter	
Juice		Canned Fish *	
Canned Vegetables		Canned Beans	
Yogurt			

Please indicate reason for restriction: ❑ Food Allergy: type_____
❑ Severe lactose maldigestion ❑ Vegan diet ❑ Other:_____

* Fully Breastfeeding moms are the only WIC participants eligible to receive canned fish. Infants are the only WIC participants eligible to receive infant meats.

❑ **Issue whole milk:** WIC provides low fat and fat free milk (1%, or skim) for children from 2 – 5 years old and women. Whole milk may be used to those with qualifying medical conditions which **also require the use of a special formula/medical food.**

❑ **Issue fat-reduced milk: WIC provides whole milk for *children 12 months – 24 months old***. Fat-reduced milks (2%, 1% or fat free) may be used to one year olds at risk of overweight or obesity.

❑ **Issue infant extra formula (6 months and older).** Infants older than 6 months with medical conditions preventing them from consuming baby foods (cereal, fruit and vegetables) may receive additional special formula.

❑ **Issue infant cereal to child** (instead of regular hot & cold cereal – must also be receiving special formula).

❑ **Issue infant fruits and vegetables (pureed) to woman or child-** must also be receiving special formula.

Additional comments / special instructions:

Please check qualifying medical condition(s): Justifies requested formula / medical food ❑ Allergy Risk Reduction
❑ Premature birth or Low Birth weight ❑ Failure to Thrive ❑ Metabolic disorders ❑ Gastrointestinal disorders
❑ Malabsorption Syndrome ❑ Immune system disorders ❑ Food allergy ❑ Dysphagia ❑ Overweight/Obesity
❑Other(s):_____

Provider's Name (Please Print):	**Signature:**

Credential: ❑ **MD** ❑ **DO** ❑ **PA** ❑ **CNP** ❑ **CNM** (Certified Nurse Midwife)
(Please check) ❑ **RD** ❑ **LD** ❑ **RN** ❑ **LPN** ❑ **LSW**

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Date_____ Medical Office / Clinic: _____
Address _____
Phone Number _____ Fax Number_____

PLEASE RETAIN A COPY FOR YOUR RECORDS AND GIVE ORIGINAL FORM TO WIC CLIENT OR FAX TO THE WIC CLINIC. CALL 202-442-9397 OR GO TO HTTP://DOH.DC.GOV/SERVICE/SPECIAL-SUPPLEMENTAL-NUTRITION-PROGRAM-WOMEN-INFANTS-AND-CHILDREN-WIC FOR THE MOST CURRENT DC WIC CLINIC LISTING.

For WIC use only:

Date Received:_____ ❑ Telephone request (follow-up written Rx within 1 month)
Comments:_____ CPA Signature_____