

INFANTS

Illinois WIC Formula and Medical Nutritional Prescription

This form must be completed by a healthcare provider, in its entirety, to receive Medically Prescribed Formula.

Patient Name (Last) (First)		Birthdate:
Parent / Caregiver (Last) (First)		
Measurement Date:	Length:	Weight:
		Birth Weight/Length:

1. PRESCRIBED FORMULA: CHOOSE ONE

Infant (0-11 months of age)

<input type="checkbox"/> Contract Formula Similac Advance, Total Comfort, Soy Isomil, Sensitive	<input type="checkbox"/> Similac NeoSure <input type="checkbox"/> ready-to-feed*	<input type="checkbox"/> Alimentum <input type="checkbox"/> ready-to-feed*	<input type="checkbox"/> Nutramigen w/Probiotic LGG <input type="checkbox"/> ready-to-feed*
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*Powder is standard issuance, ready-to-feed must meet Federal Requirements for issuance

2. FOOD PRESCRIPTION

Infant (6-11 months of age)

WIC foods will begin at 6 months unless otherwise indicated below:

No WIC foods, Formula **ONLY**

WIC Foods may include Infant Cereal, Fruits/Vegetables Jarred and/or Fresh, Frozen, Canned

3. DIAGNOSIS, AMOUNT, DURATION

NOT ALLOWED:

- **Non-Specific Symptoms or Diagnoses** include colic, constipation, diarrhea, spitting up, picky eater, fussiness, gas, etc.
- **Non-Qualifying Conditions** include those solely for enhancing nutrient intake, managing body weight, growth concerns, unconfirmed allergies, lactose intolerance, intolerance symptoms, or caregiver preference.

ALLOWED:

Qualifying Medical Conditions include specific diagnosed disorders, diseases and medical conditions that impair the ingestion, digestion, absorption, or utilization of nutrients that could adversely affect nutrition status.

<input type="checkbox"/> Low birth weight <5 lbs. 8 oz. <input type="checkbox"/> Preterm/early delivery \leq 38 weeks <input type="checkbox"/> Developmental Delay	<input type="checkbox"/> Gastroesophageal Reflux <input type="checkbox"/> Eosinophilic GI <input type="checkbox"/> Malabsorption Syndromes	<input type="checkbox"/> Food Allergy (Specify):	<input type="checkbox"/> Other Qualifying Medical Condition (Specify):
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Prescribed Amount: Maximum amount WIC provides **OR** Less than WIC provides _____ amount/day

Duration: 1 month 2 months 3 months 4 months 5 months 6 months

4. HEALTH CARE PROVIDER INFORMATION

Health Care Provider (Physician, Physician Assistant or Advanced Practice Nurse Practitioner)

Signature:

Date:

Phone:

Fax:

Printed Name:

Medical Office:

Address:

This institution is an equal opportunity provider.

CHILDREN

Illinois WIC Formula and Medical Nutritional Prescription

This form must be completed by a healthcare provider, in its entirety, to receive Medically Prescribed Formula.

Patient Name (Last) (First)		Birthdate:	
Parent / Caregiver (Last) (First)			
Measurement Date:	Length/Height:	Weight:	Birth Weight/Length:

1. PRESCRIBED FORMULA: CHOOSE ONE

Children (1 to 4 years)

<input type="checkbox"/> Contract Formula Similac Advance, Total Comfort, Soy Isomil, Sensitive	<input type="checkbox"/> Alimentum <input type="checkbox"/> ready-to-feed*	<input type="checkbox"/> Nutramigen Probiotic LGG <input type="checkbox"/> ready-to-feed*	PediaSure <input type="checkbox"/> without fiber <input type="checkbox"/> with fiber
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*Powder form is standard issuance, ready-to-feed must meet Federal Requirements for issuance

2. FOOD PRESCRIPTION

Children (1 to 4 years)

WIC foods will be provided unless otherwise indicated below:

No WIC foods, Formula **ONLY**

Jarred Infant fruits/vegetables in lieu of fresh, frozen or canned:

WIC Foods with Jarred Infant Foods

WIC foods may include: Cereal, Whole Grains, Milk, Cheese, Yogurt, Tofu, Peanut Butter, Beans, Eggs, 100% juice, Fruits & Vegetables

3. DIAGNOSIS, AMOUNT, DURATION

NOT ALLOWED:

- **Non-Specific Symptoms or Diagnoses** include colic, constipation, diarrhea, spitting up, picky eater, fussiness, gas, etc.
- **Non-Qualifying Conditions** include those solely for enhancing nutrient intake, managing body weight, growth concerns, unconfirmed allergies, lactose intolerance, intolerance symptoms, or caregiver preference.

ALLOWED:

Qualifying Medical Conditions include specific diagnosed disorders, diseases and medical conditions that impair the ingestion, digestion, absorption, or utilization of nutrients that could adversely affect nutrition status.

<input type="checkbox"/> Prematurity (up to 2 years) <input type="checkbox"/> Developmental Delay	<input type="checkbox"/> Gastroesophageal Reflux <input type="checkbox"/> Eosinophilic GI <input type="checkbox"/> Malabsorption Syndromes	<input type="checkbox"/> Food Allergy (Specify):	<input type="checkbox"/> Other Qualifying Medical Condition (Specify):
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Prescribed Amount: Maximum amount WIC provides **OR** Less than WIC provides _____ amount/day

Duration: 1 month 2 months 3 months 4 months 5 months 6 months

4. HEALTH CARE PROVIDER INFORMATION

Health Care Provider (Physician, Physician Assistant or Advanced Practice Nurse Practitioner)

Date:

Signature:

Phone:

Fax:

Printed Name:

Medical Office:

Address:

This institution is an equal opportunity provider.