REQUIRED MEDICAL DOCUMENTATION FOR WIC FORMULA AND APPROVED WIC FOODS - PREGNANT, BREASTFEEDING, AND NON-BREASTFEEDING POSTPARTUM WOMEN

State Form 55324 (R4 / 5-19)
INDIANA STATE DEPARTMENT OF HEALTH
INDIANA WOMEN, INFANTS, & CHILDREN PROGRAM (WIC)

Patient's Name: _____ **Birthdate** *(mm/dd/yyyy)*: _____

Attention Clinic Staff: **Scan this form into the Client Section of the INWIC Communication screen.**
A Release of Information Form must be signed and scanned before faxing to the healthcare provider. – Thank you.

PLEASE COMPLETE EACH SECTION FOR YOUR PREGNANT OR POSTPARTUM PATIENT.

1. Qualifying medical condition(s) include, but are not limited to: *(Check all that apply.)*

- ☐ Gastrointestinal disorders
- ☐ Malabsorption syndromes
- ☐ Immune system disorders
- ☐ Severe food allergies that require an elemental formula
- ☐ Inborn errors of metabolism and metabolic disorders
- ☐ Disease and medical conditions that impair ingestion, digestion, absorption, or the utilization of nutrients that could adversely affect the participant's nutrition status

2. Name of WIC standard infant or exempt infant formula / WIC-eligible nutritionals prescription:

_____

Prescribed amount per day: _____

Physical Form: ☐ Powder ☐ Concentrate ☐ Ready to Use

Special instructions for preparation and use: _____

3. Allowed WIC foods *(Please check appropriate boxes.)*

☐ ***No foods***	☐ ***All foods EXCEPT (Check all that apply.)***	
☐ ***All foods*** (Women receive 1% or Skim milk only.) (Soy Milk and Tofu can be made available unless indicated as an exception in the "All Foods Except" box.)	☐ Breakfast cereal	☐ 100% juice
	☐ Fresh / frozen / canned fruit and vegetables	☐ Yogurt
	☐ Eggs	☐ Whole wheat bread or other whole grains (fully and partially breastfeeding women only)
	☐ Cheese	
	☐ Milk	☐ Beans or peanut butter
	☐ Soy Milk	☐ Fish (fully breastfeeding women only)
	☐ Tofu	

The following choices may be provided for patients who have a qualifying condition. Please check all that apply. A length of use is still required when ordering these items. (Formula or WIC-eligible nutritionals are not required for the patient to receive these items.)

☐ Whole milk	☐ 2% Milk	☐ Infant cereal (in place of breakfast cereal)	☐ Pureed fruits and vegetables (in place of fresh / frozen / canned fruit and vegetables)

4. Length of use for this prescription: ☐ 1 month ☐ 3 months ☐ 6 months ☐ 12 months

Other: _____

SIGNATURE *(Health Care Provider)*: _____ Date *(mm/dd/yyyy)*: _____

Printed Name *(Health Care Provider)*: _____

Medical Office / Clinic: _____ Telephone: _____

Address *(number and street, city, state, and ZIP code)*: _____

WIC Staff Use Only: Non-qualifying conditions:
• Food intolerance, • Patient preference, • Management of body weight with no underlying medical condition

This institution is an equal opportunity provider.