Print Form

TENNESSEE DEPARTMENT OF HEALTH
REQUEST FOR WIC ELIGIBLE THERAPEUTIC PRODUCTS AND SUPPLEMENTAL FOODS

MUST BE COMPLETED BY HEALTHCARE PROVIDER

Patient's Name: _____ Date of Birth: _____

Formula Requested: _____ Dilution Strength (if > standard for product): _____

Amount per 24 hours ☐ maximum allowed or ☐ _____ day Tube fed: ☐ Y ☐ N

Length of issuance for infants: ☐ 1 MO ☐ 2 MO ☐ 3 MO

Length of issuance for woman or child: ☐ 1 MO ☐ 2 MO ☐ 3 MO ☐ 4 MO ☐ 5 MO ☐ 6 MO

Most recent: Date of measures: _____ Weight: _____ (lbs or kg) Ht/Length: _____ (inches or cm)

Serious Nutritionally Related **WIC Qualifying Condition**: _____

If severe food allergy must specify the confirmed allergic disorder:

- ☐ Gastrointestinal anaphylaxis
- ☐ Eosinophilic gastroenteritis
- ☐ Food protein induced - enterocolitis
- ☐ Acute or chronic urticaria & angioedema
- ☐ Eosinophilic esophagitis
- ☐ Food protein - induced proctocolitis
- ☐ Food protein - enteropathy, celiac
- ☐ Atopic disease

Clinical Findings, Current Medications, and Laboratory Data: _____

_____

The participant will receive the supplemental foods, appropriate to their WIC participant category, listed below in addition to the WIC formula/medical food. Please indicate any supplemental foods or restrictions that would be contraindicated with the participant's medical diagnosis.

Infants (6 through 11 months)		Children & Women	
Do Not Give	Age Appropriate Food	Do Not Give	WIC Foods
☐	Infant Cereal	☐	Milk
☐	Infant Food Vegetables/Fruits	☐	Cheese
		☐	Cereal
		☐	Juice
		☐	Eggs
		☐	Vegetables/Fruits
		☐	Peanut Butter
		☐	Whole Grain Products
		☐	Dried Beans or Peas
		☐	Canned Fish (Breastfeeding women only)
		☐	Soy Beverage and/or Tofu (women only)

PRESCRIBING HEALTH CARE PROVIDER (HCP):

Signature (include credentials): _____ Date of Request: _____

Name (please print): _____

Contact Phone: (_____) _____ Fax: (_____) _____

Address: _____

REQUEST IS SUBJECT TO TN WIC APPROVAL AND PROVISION BASED ON PROGRAM REGULATION AND POLICY

WIC Use Only _____