Rhode Island Department of Health WIC Program
Medical Documentation for WIC Nutritionals 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 WIC-eligible formula/nutritional and/or changes to their supplemental food package.

A. Patient Information (Complete All)

Patient's Name: DOB:

**Medical Diagnosis/Qualifying Condition(s):

** **Please Note**: The following non-specific terms are **NOT** acceptable as qualifying conditions: lack of appetite, slow weight gain, weight maintenance, or inability to prepare meals.

B. WIC-Eligible Formula / Nutritionals

Name of formula / nutritional requested:

Prescribed amount: oz per day

Requested length of issuance (please circle): 1 2 3 4 5 6 Months

C. WIC Food Restrictions / Requests (Please Check All That Apply)

- ☐ No food restrictions
- ☐ Defer to WIC Nutrition professional to determine appropriate supplemental foods **OR**
- ☐ MD will determine supplemental food restrictions **(Complete section D)**
- ☐ Needs pureed consistency due to medical condition and inability to consume table foods
- ☐ Issue WIC-eligible formula / nutritionals only, do not issue other WIC foods
- ☐ Issue whole milk (in place of non-fat or 1% milk) in addition to WIC-eligible formula / nutritionals

D. Complete this section only if MD is NOT deferring to WIC Nutrition professional

Do **not** issue the WIC foods below:

- ☐ Milk
- ☐ Yogurt
- ☐ Cheese
- ☐ Eggs
- ☐ Peanut butter
- ☐ Bread, rice, pasta, tortillas
- ☐ Cereal
- ☐ Juice
- ☐ Beans (dried / canned)
- ☐ Fruits and vegetables

E. Health Care Provider Information

Provider's Name (please print):

Signature of health care provider:

Address:

Phone: Fax#: Date: