



Rhode Island Department of Health WIC Program
Medical Documentation for WIC Nutritional and Approved WIC Foods
Children 1 – 5 years old



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:	Date of Birth:	
Parent/Guardian Name:		
**Medical Diagnosis/Qualifying Conditions(s):		
<p>**Please Note: The following non-specific terms are NOT acceptable as qualifying conditions: constipation, feeding difficulty, picky eater, poor appetite, non-specific intolerance. Formula requests received with these terms will not be approved.</p>		
B. WIC-Eligible Formula/Nutritional		
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)	D. Complete this section only if a MD is not deferring to WIC Nutrition professional	
<ul style="list-style-type: none"> <input type="checkbox"/> No food restrictions <input type="checkbox"/> Request WIC Nutrition professional to determine food restrictions <li align="center">OR <input type="checkbox"/> MD will determine food restrictions (Complete section D) <input type="checkbox"/> Needs pureed consistency due to medical condition and inability to consume table foods <input type="checkbox"/> Issue WIC-eligible formula / nutritionals only. Do not issue other WIC foods <input type="checkbox"/> Issue whole milk to a child >2 years in addition to WIC-eligible formula/nutritionals <input type="checkbox"/> Issue non-fat or 1% milk to a child 12-23 months old who has a w/l % > 97.9 on CDC growth charts 	<p>Do not issue the WIC foods below:</p> <ul style="list-style-type: none"> <input type="checkbox"/> Milk <input type="checkbox"/> Yogurt <input type="checkbox"/> Cheese <input type="checkbox"/> Eggs <input type="checkbox"/> Peanut butter <input type="checkbox"/> Bread, rice, pasta, tortillas <input type="checkbox"/> Cereal <input type="checkbox"/> Juice <input type="checkbox"/> Beans (dried/canned) <input type="checkbox"/> Fruits and vegetables 	
E. Healthcare Provider Information		
Provider's Name (please print):		
Signature of healthcare provider:		
Address:		
Phone:	Fax:	Date: