SECTION 1: Include Patient Name, DOB, and Parent/ Guardian Name.

SECTION 2:

- ☐ Select box for appropriate medical diagnosis; ICD code will NOT be accepted.
- ☐ Indicate other diagnoses not in the selections; If no clear medical diagnosis can be made, describe all symptoms related to why the individual needs a special formula.

SECTION 3: WIC maximums are set by federal regulations. Maximums are determined by age and category. Check WIC website at www.mdwic.org for more information.

SECTION 4: Select how long the formula or supplement will be needed.

SECTION 6:

- ☐ Circle appropriate credentials
- ☐ Print name or use office stamp
- ☐ Date WHEN FORM WAS COMPLETED
- ☐ BOTH Signature AND credentials must be present for the form to be accepted.

WIC MARYLAND
BETTER NUTRITION, BRIGHTER FUTURE

WIC Clinic:
Fax:
Phone:
Email:

Medical Documentation Form

Issuance is subject to WIC approval based on Program Policy and Procedure. Maryland WIC Program does not provide non-contract standard milk and soy-based infant formulas without medical documentation. Our contract formulas are Similac Advance or Similac Soy Isomil. Please contact the Local WIC Agency (see back of form) with any questions.

1) Patient Information

Patient Name: _____ **Patient DOB:** _____

Parent/Guardian: _____

Patient Medical Data (optional):	Weight:	Length/height:	Hgb:
Date Measured:			

2) Qualifying Medical Condition

☐ Low Birth Weight ☐ Prematurity (weeks gestation____) ☐ GER/GERD
☐ Failure to Thrive ☐ Cow's Milk Protein Allergy ☐ Food Allergies (specify): _____
☐ Malabsorption ☐ Cow's Milk Protein Intolerance ☐ Other ***(no ICD codes)***: _____

Additional Comments/Symptoms: _____

3) Formula/WIC Eligible Nutritional Requested

Product Requested: _____ **Amount per day:** _____(oz)

Calorie Level: ☐ Standard dilution ☐ Other: _____kcal/oz

4) Duration

☐ 1 month ☐ 3 months ☐ 6 months ☐ 12 months ☐ Until 1 year old

5) WIC Food Requests **Check ONE box below**

***Note:** Infant supplemental foods begin at 6 months old; they include infant/fresh fruits & vegetables and infant cereal**
For detailed information on the supplemental foods WIC provides please visit www.mdwic.org or call your local WIC clinic.

Does the patient have any food restrictions?

☐ **No:** WIC Professional may determine WIC foods and amounts.
☐ **Yes:** (must specify): _____
_____

6) Health Care Provider with Prescriptive Authority

Circle Credentials: MD, DO, PA, NP/CNP/CRNP/DNP, APN, CNM, CRNA, CNS, MBBS, MBBCh

Name: (Please print, type or stamp)_____

Phone: _____ Fax:_____

Signature and Credentials: _____ Date: _____

WIC use only: ☐ Approved ☐ Not Approved ☐ Pending	Comments:
Signature:_____ Date:	

Website: www.mdwic.org. Click on the Health Care Providers section for more information.

SECTION 5:
Check only **ONE** box if there are any food restrictions.

NO - WIC Professional May Determine WIC Foods and Amounts - gives WIC staff the ability to customize other parts of the food package to best meet participants' needs.
YES - must specify foods to avoid or not to be included in the WIC food package.

TO SUBMIT:

Submit completed form via fax or email to the designated WIC Local Agency listed on Page 2 of 3.02C Medical Documentation Form.