Alabama WIC Child/Woman Formula Prescription
Child (12 Months of Age and Older) or Woman

Prescription is subject to WIC approval and provision based on program policy and procedures.

PARTICIPANT INFORMATION

Participant's name:	**DOB:**
Medical condition(s) indicating need for prescribed product(s): *Federal Regulations prevent formula issuance solely for the purpose of enhancing nutrient intake or managing body weight without an underlying medical condition.*	
Anthropometric Data – Required when Increased Calorie Supplements are prescribed: Date of Measurement _____ Weight _____ lb. ___oz. Length/Height __ ft. __in. BMI_____	

FORMULA/PRODUCT AND WIC SUPPLEMENTAL FOODS

Formula/product prescribed:

Amount per day ❑ 8ozs (1can QD**)** ❑ 16ozs (1can BID) ❑ 24ozs (1can TID) ❑ Other*****

**Amount per day cannot exceed 30 ounces (maximum issuance allowed by USDA). Monthly clinic visits are required if 30 ounces per day is prescribed.*

Intended length of use: ❑ 1 ❑ 2 ❑ 3 ❑ 4 ❑ 5 ❑ 6 months

- After 6 months a new prescription is required
- If prescription is not renewed, no formula can be issued

Special instructions for preparation or dilution:

_____

Supplemental Food Available: In addition to formula prescribed, the WIC Program may provide supplemental foods as ordered by the health care provider. *These items not allowed with Elemental/Amino Acid formulas.

••• WIC RD/Nutritionist will determine the food package unless denoted otherwise. •••

Please check all items to be REMOVED from the food package:

❑ Milk/Soy Milk *	❑ Fruit/Vegetables
❑ Cheese *	❑ Cereal
❑ Yogurt *	❑ Peanut/Nut/Seed Butter
❑ Eggs	❑ Canned Fish (Tuna/Salmon)
❑ Juice	❑ Canned or Dry Beans or Peas
❑ Whole Grain Bread/Tortilla/Pasta/Brown Rice/Oats	

HEALTH CARE PROVIDER INFORMATION

Signature of Health Care Provider:		
Health Care Provider's name (please print):		
Health Care Practice/Clinic:		
Phone #:	**Fax #:**	**Date:**

WIC Clinic Approval

Participant ID#_____ **Date Received**_____ **Approved by**_____

Alabama WIC Child/Woman Formula Prescription (ADPH-WIC-111b)
Instructions for Completion of Form

Click here to view the Alabama WIC Formulary with Qualifying Conditions:

IMPORTANT – Only this form will be accepted by WIC clinics for special formula requests.

Participant's Name: Enter name of the participant requiring the special formula.

Date of Birth (DOB): Enter the participant's date of birth.

ICD-10 Code and/or Medical Diagnosis/Condition(s): Document the medical diagnosis and/or the corresponding ICD-10 code. The prescription may be accepted if either the medical diagnosis or the ICD-10 code is written. However, the medical diagnosis and/or the ICD-10 code must be a nutrition related medical diagnosis/ICD-10 code.

Anthropometric Data: Enter the Date of measurement, weight, length/heigh, and BMI (if applicable) if formula request is for an Increased Calorie Supplement.

Formula Prescribed: Enter the name of the special medical formula prescribed.

Amount per Day: Check the box or enter the amount of formula per day. (Maximum issuance per day allowed by USDA is 30 oz.)

Intended length of use: Check the number of months formula is needed. Note that the participant's need for the special formula must be re-evaluated by the health care provider every six (6) months.

Special Instructions for preparation or dilution: Must be completed if standard mixing instructions per package instructions are not prescribed.

Supplemental Foods Available: Check all WIC foods that participant **may not** consume while receiving special formula. If nothing is checked, WIC RD/Nutritionist will determine the food package.

Signature of Health Care Provider: The health care provider's signature must be entered.

Provider's Name printed: PRINT name of the health care provider.

Health Care Practice/Clinic: Print provider's practice/clinic name.

Phone: Enter the phone number of the health care provider.

Fax: Enter the fax number of the health care provider, if applicable.

Date: Enter date of prescription.

WIC Clinic Use Only: Information is required to be completed.

Participant #: Enter the participant's participant ID number.

Date Received: Enter the date the clinic receives the prescription form.

Approved by: Enter the name of the WIC Provider approving the acceptance of the prescription.

***NOTE: A health care provider is a Physician or someone working under Physician's orders, such as a Physician Assistant or Nurse Practitioner.**