

## 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

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

### FORMULA/PRODUCT AND WIC SUPPLEMENTAL FOODS

<b>Formula/product prescribed:</b>												
<b>Amount per day</b> <input type="checkbox"/> 8ozs (1can QD) <input type="checkbox"/> 16ozs (1can BID) <input type="checkbox"/> 24ozs (1can TID) <input type="checkbox"/> Other* <i>*Amount per day cannot exceed 30 ounces (maximum issuance allowed by USDA). Monthly clinic visits are required if 30 ounces per day is prescribed.</i>												
<b>Intended length of use:</b> <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6 months <ul style="list-style-type: none"> <li>• After 6 months a new prescription is required</li> <li>• If prescription is not renewed, no formula can be issued</li> </ul>												
<b>Special instructions for preparation or dilution:</b>												
<hr/> <b>Supplemental Food Available:</b> 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. <p style="text-align: center;">••• WIC RD/Nutritionist will determine the food package unless denoted otherwise. •••</p> <p style="text-align: center;"><b><u>Please check all items to be REMOVED from the food package:</u></b></p> <table style="width: 100%; border: none;"> <tr> <td style="width: 50%;"><input type="checkbox"/> Milk/Soy Milk *</td> <td style="width: 50%;"><input type="checkbox"/> Fruit/Vegetables</td> </tr> <tr> <td><input type="checkbox"/> Cheese *</td> <td><input type="checkbox"/> Cereal</td> </tr> <tr> <td><input type="checkbox"/> Yogurt *</td> <td><input type="checkbox"/> Peanut/Nut/Seed Butter</td> </tr> <tr> <td><input type="checkbox"/> Eggs</td> <td><input type="checkbox"/> Canned Fish (Tuna/Salmon)</td> </tr> <tr> <td><input type="checkbox"/> Juice</td> <td><input type="checkbox"/> Canned or Dry Beans or Peas</td> </tr> <tr> <td colspan="2"><input type="checkbox"/> Whole Grain Bread/Tortilla/Pasta/Brown Rice/Oats</td> </tr> </table>	<input type="checkbox"/> Milk/Soy Milk *	<input type="checkbox"/> Fruit/Vegetables	<input type="checkbox"/> Cheese *	<input type="checkbox"/> Cereal	<input type="checkbox"/> Yogurt *	<input type="checkbox"/> Peanut/Nut/Seed Butter	<input type="checkbox"/> Eggs	<input type="checkbox"/> Canned Fish (Tuna/Salmon)	<input type="checkbox"/> Juice	<input type="checkbox"/> Canned or Dry Beans or Peas	<input type="checkbox"/> Whole Grain Bread/Tortilla/Pasta/Brown Rice/Oats	
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### HEALTH CARE PROVIDER INFORMATION

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

<b>WIC Clinic Approval</b>		
<b>Participant ID#</b> _____	<b>Date Received</b> _____	<b>Approved by</b> _____

**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/height, 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.**