REQUIRED MEDICAL DOCUMENTATION FOR WIC FORMULA AND APPROVED WIC FOODS - PREGNANT, BREASTFEEDING, AND NON-BREASTFEEDING POSTPARTUM WOMEN

State Form 55324 (R2 / 4-15)
INDIANA STATE DEPARTMENT OF HEALTH
INDIANA WOMEN, INFANTS, & CHILDREN PROGRAM (WIC)

Patient's Name: _____ **Birthdate** *(mm/dd/yyyy)*: _____

Minor Prenatal or Postpartum Patient's Parent/Guardian/Caretaker Name: _____

PLEASE COMPLETE EACH SECTION FOR YOUR PREGNANT OR POSTPARTUM PATIENT.

1. Qualifying medical condition(s) include, but are not limited to: *(Check all that apply.)*

- ☐ Gastrointestinal disorders
- ☐ Malabsorption syndromes
- ☐ Immune system disorders
- ☐ Severe food allergies that require an elemental formula
- ☐ Inborn errors of metabolism and metabolic disorders
- ☐ Disease and medical conditions that impair ingestion, digestion, absorption, or the utilization of nutrients that could adversely affect the participant's nutrition status

2. Name of WIC standard infant formula/exempt infant formula/WIC-eligible nutritionals prescription:

_____

Prescribed amount per day: _____

Physical Form: ☐ Powder ☐ Concentrate ☐ Ready to Use

Special instructions for preparation and use: _____

3. Allowed WIC foods *(Please check appropriate boxes.)*

☐ ***No foods***	☐ ***All foods EXCEPT (Check all that apply.)***
☐ ***All foods*** (Women receive 1% or Skim milk only.)	☐ Breakfast cereal ☐ Fresh/frozen fruits and vegetable ☐ Eggs ☐ Cheese ☐ Milk ☐ Yogurt ☐ 100% juice ☐ Whole wheat bread or other whole grains (fully and partially breastfeeding women only) ☐ Beans or peanut butter (>2yrs) ☐ Fish (fully breastfeeding women only)

The following choices may be provided for patients who have a qualifying condition. Please check all that apply. A length of use is still required when ordering these items. (Formula or WIC-eligible nutritionals are not required for the patient to receive these items.)

☐ Whole milk	☐ 2% Milk	☐ Infant cereal (in place of breakfast cereal)	☐ Pureed fruits and vegetables (in place of fresh/frozen fruits and vegetables

4. Length of use for this prescription: ☐ 1 month ☐ 3 months ☐ 6 months ☐ 12 months

Other: _____

SIGNATURE *(Health Care Provider)*: _____ Date *(mm/dd/yyyy)*: _____

Printed Name *(Health Care Provider)*: _____

Medical Office/Clinic: _____ Telephone: _____

Address *(number and street, city, state, and ZIP code)*: _____

WIC Staff Use Only: Non-qualifying conditions:

• food intolerance, • Patient preference, • Management of body weight with no underlying medical condition