

Request for Medically Necessary Formulas/Medical Nutritional Products from the Texas WIC Program

Dear Health Care Provider: The Texas WIC program issues contract formulas - Similac Advance, Similac Isomil Advance, Similac Sensitive, Similac with Iron, and Isomil with Iron. Other formulas/medical nutritional products may be issued for a valid medical reason. Please provide the following information when requesting a non-contract formula.

Patient's Name _____ DOB: _____ Birth weight _____ Weeks gestation _____
 Current Weight _____ Current Length _____ Date of measurements _____

 Signature and title (MD, DO, NP, PA) Printed Name Date Phone Number

Note: Federal regulations limit the amount of formula WIC can provide to any one participant. An infant, child, or pregnant or postpartum woman who is Medicaid-eligible may be able to obtain additional formula/medical nutritional product through that program, if needed.

	Infant	Child/Woman
Ready-to-Use	806 fl oz.	910 fl oz.
Powder	8 lbs	9lbs
Liquid Concentrate	403 fl oz	455 fl oz.

Ready to use products may only be provided if the caregiver is physically or mentally incapable of preparing formula, there is an unsafe or unsanitary water supply, or the formula is not available in any other form, i.e., liquid concentrate or powder.

Formula/Nutritional Product(s)	Medical Reason for Request	Requested Duration

Texas WIC Program Authorization to Release Medical Information

Name: _____
(Name of Formula Recipient)

I authorize the following health care provider, _____, to release medical information to the Texas WIC Program Local Agency. The information released will be used for and is required in the approval process to determine issuance of medically prescribed formula to the above named client. This form was read by me was read to me and I understand its meaning.

(Signature of participant/parent/guardian/caregiver) Date _____

(Print the Name of Above Person Authorized to Consent to Release of Information) (Relationship to Client)

Nombre: _____
(Nombre de recipiente de la formula)

Doy mi autorización para que el siguiente proveedor de atención médica, _____, divulgue la información médica a la agencia local del Programa WIC de Texas. La información divulgada es necesaria y se usará y se exige durante el proceso de aprobación para determinar la concesión de la fórmula rectada por el médico a la cliente antes mencionada. Yo leí este formulario Alguien me lo leyó y yo entiendo y acepto lo que dice.

(Firma del participante/padres/tutor/persona que los cuida) Fecha _____

(Escriba con letra de molde el nombre de la persona autorizada para dar el consentimiento a la divulgación de la información) (Parentesco con la cliente)



This side for WIC staff only.

Local Agency #	Clinic Site #	Staff Collecting Information:	SA Problem Number:
Participant's Name:		FID/PAN:	
DOB:	Birth Weight:	Weeks Gestation:	
Date of most recent measurements:		Growth Percentiles:	
Length/Height:		Wt-for-Length or Ht:	BMI-for-Age:
Weight:		Length-for-Age:	Adjusted for Prematurity: Y N
		Weight-for-Age:	Adjusted for Prematurity: Y N
Formula Requested:		Requested Length of Issue:	
Formula History and Reactions:			
Diagnosis/medical condition or suspected diagnosis (signs or symptoms):			
Medications:			
Diet Recall:			
Comments/Recommendations prior to next issuance:		Referred to:	
Approved Length of Issuance:		Expiration Date:	
Food Package Code:	Formula Code:	Amount Issued:	
Name of Approving Authority		Today's Date:	

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