Family or Participant ID#_____

State of Connecticut WIC Program-Department of Public Health

MEDICAL DOCUMENTATION FOR WIC FORMULA AND APPROVED WIC FOODS

INFANTS AND CHILDREN

Patient's Name: _____ **Date of Birth (DOB):** ___/___/___

Parent/Guardian: _____ **Weeks Gestation (premature infants):** _____

The Connecticut WIC Program strongly endorses breastfeeding as the optimal method to feed most infants. For infants that do consume formula, Connecticut WIC standard formulas are *Similac® Advance® 20cal/oz.* and *Similac® Isomil® Soy 20cal/oz. Similac® Sensitive® 19cal/oz.* and *Similac® Total Comfort® 19cal/oz.* are standard formulas approved in Connecticut requiring medical documentation. For more information or additional copies of this form please visit our website: www.ct.gov/dph/wic, then click on "For Medical Providers" tab in the left navigation bar.

Formula requested: _____

Prescribed ounces per day* (unless ad lib): _____ ☐ Powder ☐ Concentrate ☐ Other _____

☐ Check here to request one of the following: ☐ ***Similac® Sensitive®* (19 cal/oz.)** ***or*** ☐ ***Similac® Total Comfort®* (19 cal/oz.)**

☐ Check here to request ***Similac® For Spit-Up®* (19 cal/oz.) must have** documented Gastroesophageal Reflux or Other ICD-10 code.

Instructions for preparation: _____

Caloric density: ☐ 19cal/oz. ☐ 20cal/oz. ☐ 22cal/oz. ☐ 24cal/oz. ☐ 26cal/oz. ☐ 30cal/oz. ☐ Other: _____

Length of use: ☐ 1 month ☐ 2 months ☐ 3 months ☐ 4 months ☐ 5 months ☐ 6 months

In order to obtain an exempt/special formula from WIC, an ICD code(s) and qualifying medical condition must be identified. Non-specific symptoms such as intolerance, fussiness, gas, spitting up, constipation and colic are not considered qualifying conditions. A WIC Nutrition Professional will complete a dietary assessment to determine the need for the requested formula. Significant findings will be communicated to you with the participant's permission. It is WIC's policy to re-evaluate the continued need for the formula on a periodic basis. The WIC Program does not provide whole cow's milk for infants. ***WIC is a supplemental nutrition program and may not provide the total amount of formula or food prescribed.*** Prescription is subject to WIC approval and provision is based on Program policy and procedure. ***No prescription is valid for more than six months.***

REQUIRED: Select qualifying medical condition(s)/ICD-10 code(s)

☐ Allergy, Food (L27.2	☐ Cystic Fibrosis (E84.9)	☐ Lactose Intolerance (E74.39)
☐ Anemia (D53.9)	☐ Developmental Delay (R62.50)	☐ Malabsorption (K90.9)
☐ Autoimmune Disorder (M35.9)	☐ Diabetes Mellitus Type I (E10.9)	☐ Neuromuscular Disorder (G70.9)
☐ Congenital Heart Disease (Q24.9)	☐ Failure to Thrive/Inadequate Growth (R62.51)	☐ Prematurity (P07.30)
☐ Congenital Anomaly, Respiratory (Q34.9)	☐ Galactosemia (E74.21)	☐ Phenylketonuria (PKU) (E70.0)
☐ Congenital Anomaly, GI (Q45.9)	☐ Gastroesophageal Reflux (K21.9)	☐ Other diagnosis with ICD-10 code
☐ Cleft Palate (Q35.9)	☐ Immunodeficiency (D84.9)	Specify _____
☐ Cerebral Palsy (G80.9)		

Medical Documentation for Whole Milk for Children 2-5 Years of Age:

If child is over 2 years of age, does he/she require whole milk based on a qualifying condition? ☐ **Yes** ☐ **No**

Children age 2 or older who are receiving formula for a qualifying medical condition and also receive milk are provided fat reduced milk. Whole milk can be provided if based on a documented qualifying medical condition that warrants the use of a high calorie special formula or supplement.

Medical Documentation for Fat-Reduced Milks for Children 12-23 Months of Age:

If the child is 12-23 months of age does he/she require fat reduced milk based on overweight or obesity? ☐ **Yes** ☐ **No** **Specify:** _____

Please specify 2%, 1% or skim. Whole milk is the standard milk given to children 12-23 months of age. Fat-reduced milk (2%, 1% or skim) can be provided for children 12-23 months when overweight or obesity is a concern.

WIC Supplemental Foods Available Please check foods that are **not allowed** based on medical diagnosis

☐ Milk, Specify type: _____	☐ Whole wheat bread /whole grains	☐ Peanut butter	☐ All foods contraindicated
☐ Soy Milk/ Tofu	☐ Breakfast cereal	☐ Vegetables and fruits	☐ Restrictions in amounts:
☐ Cheese	☐ Whole grain pasta	☐ Infant cereal	Explain: _____
☐ Yogurt	☐ Legumes (beans/peas)	☐ Infant food vegetables/ fruits	_____
☐ Juice	☐ Eggs		

***REQUIRED:* Refer to WIC Nutrition Professional to identify appropriate types and amounts of WIC supplemental foods*.** ☐ Yes ☐ No

***By checking this box you authorize the WIC Nutrition Professional to make future decisions about WIC supplemental foods.**

HEALTH CARE PROVIDER SIGNATURE: _____ **Date:** _____
(MD, APRN or PA)

Printed Name (Health Care Provider): _____ Phone: _____

Provider Stamp or Address: Fax:

WIC Use Only: Date received _____ **Contacted HCP?** ☐ **Yes** ☐ **No**

CPA Signature: _____ **Date:** _____

Family or Participant ID#_____

State of Connecticut WIC Program-Department of Public Health

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☐ Cleft Palate (Q35.9)	☐ Immunodeficiency (D84.9)	Specify _____
☐ Cerebral Palsy (G80.9)		

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Medical Documentation for Fat-Reduced Milks for Children 12-23 Months of Age:

If the child is 12-23 months of age does he/she require fat reduced milk based on overweight or obesity? ☐ **Yes** ☐ **No** **Specify:** _____

Please specify 2%, 1% or skim. Whole milk is the standard milk given to children 12-23 months of age. Fat-reduced milk (2%, 1% or skim) can be provided for children 12-23 months when overweight or obesity is a concern.

WIC Supplemental Foods Available Please check foods that are **not allowed** based on medical diagnosis

☐ Milk, Specify type: _____	☐ Whole wheat bread /whole grains	☐ Peanut butter	☐ All foods contraindicated
☐ Soy Milk/ Tofu	☐ Breakfast cereal	☐ Vegetables and fruits	☐ Restrictions in amounts:
☐ Cheese	☐ Whole grain pasta	☐ Infant cereal	Explain: _____
☐ Yogurt	☐ Legumes (beans/peas)	☐ Infant food vegetables/ fruits	_____
☐ Juice	☐ Eggs		

***REQUIRED:* Refer to WIC Nutrition Professional to identify appropriate types and amounts of WIC supplemental foods*.** ☐ Yes ☐ No

***By checking this box you authorize the WIC Nutrition Professional to make future decisions about WIC supplemental foods.**

HEALTH CARE PROVIDER SIGNATURE: _____ **Date:** _____
(MD, APRN or PA)

Printed Name (Health Care Provider): _____ Phone: _____

Provider Stamp or Address: Fax:

WIC Use Only: Date received _____ **Contacted HCP?** ☐ **Yes** ☐ **No**

CPA Signature: _____ **Date:** _____

State of Connecticut WIC Program-DEPARTMENT OF PUBLIC HEALTH
CERTIFICATION/MEDICAL REFERRAL FORM - INFANTS AND CHILDREN

Participant ID #: _____ Family ID #: _____

Child's Name: _____ **Date of Birth (DOB):** ___/___/_____ **Sex:** M / F

Parent/Guardian: _____ **Phone:** (___) _____

Address: _____

DATE COLLECTED:	**DATE COLLECTED:**	**FOR INFANTS AND CHILDREN < 2:**
Weight:	**Hemoglobin:**	**Birth Weight:**
Length or Height:	**Hematocrit:**	**Birth Length:**
Body Mass Index (BMI):	**Lead test done? Y or N**	**Birth Head Circ. (optional):**
Head Circ. (optional):	**Date collected: Result:**	**Immunizations Up-to-date? Y N**
Medications/Medical Problems/Concerns:		

ANTHROPOMETRIC

0-23 months (Based on 2006 WHO Growth Standards)

1a. ☐ Underweight (≤ 2.3rd percentile wt/length)
1b. ☐ At Risk of Underweight (>2.3rd percentile and ≤ 5th wt/length)
2. ☐ High Weight for Length (≥ 97.7th percentile wt/length)
2b. ☐ At Risk of Overweight- Parent with BMI ≥ 30
3a. ☐ Short Stature (≤ 2.3rd percentile length/age)
3b. ☐ At Risk for Short Stature (> 2.3rd & ≤ 5th percentile length/age)
4. ☐ Failure to thrive
5. ☐ Slowed/Faltering Growth Pattern
6. ☐ LBW (birth weight < 5.5 pounds or < 2500 grams)
7. ☐ Prematurity (< 37 weeks gestation) **# weeks gestation** ____
8a. ☐ Small for gestational age (based on medical diagnosis)
8b. ☐ Large for gestational age (≥ 9 lbs) (up to 12 months)
9. ☐ Head circumference ≤ 2.3rd percentile (up to 24 months)

2-5 years (Based on 2000 CDC age/gender specific growth charts)

1a. ☐ Underweight (≤ 5th percentile BMI-for-age)
1b. ☐ At Risk of Underweight (>5th and ≤10th percentile BMI-for-age)
2a. ☐ Obese (≥ 95th percentile BMI-for-age)
2b. ☐ Overweight (≥ 85th or <95th percentile BMI-for-age)
2b. ☐ At Risk of Overweight- Parent with BMI ≥ 30
3a. ☐ Short Stature (≤ 5th percentile height/age)
3b. ☐ At Risk for Short Stature (>5th and ≤ 10th percentile ht/age)
4. ☐ Failure to thrive

Weight, length/height measurements must be within 60 days of the WIC certification.

BIOCHEMICAL (1998 CDC Standards)

10. ☐ Anemia **6-23 Mos:** Hgb < 11g/dl, Hct < 32.9%;
2-5 yrs: Hgb < 11.1 g/dl, Hct < 33%)

11. ☐ Elevated blood lead level (≥ 5ug/dl in last 12 months)

CLINICAL/ HEALTH/ MEDICAL

12. ☐ Nutrient deficiency disease. Specify _____
13. ☐ Gastrointestinal disorder. Specify _____
14. ☐ Nutritionally significant genetic or congenital disorder.
Specify _____
15. ☐ Nutrition related infectious disease. ☐ Acute ☐ Chronic
Specify _____
16. ☐ Nutrition related non-infectious chronic disease.
Specify _____
17. ☐ Food allergy. Specify _____
18. ☐ Other nutrition related medical conditions.
Specify _____
19. ☐ Oral health conditions. Specify _____
20. ☐ Fetal Alcohol Syndrome
21. ☐ Infant born of a woman with mental retardation
22. ☐ Infant born of a woman who abused alcohol or drugs during most recent pregnancy
23. ☐ Breastfeeding complications or potential complications.
Specify _____
24. ☐ Breastfeeding infant of woman at nutritional risk
☐ non-dietary; ☐ dietary

DIETARY (Document in CT-WIC)

25. ☐ Specify code(s) _____
☐ Improper use of bottle/cup or (pacifier-Child only) ☐ Potentially harmful microorganisms/toxins ☐ Feeding sugar containing fluids

OTHER NUTRITIONAL RISKS

26. ☐ Infant (0-6 months) of a mother enrolled in WIC or of a woman who would have been WIC eligible during pregnancy
27. ☐ Possible regression in nutritional status if removed from the Program ☐ non-dietary; ☐ dietary
28. ☐ Homelessness or migrancy
29. ☐ Entering or moving within the foster care system during the previous 6 months
30. ☐ Other risks. Specify _____

Health Care Provider Signature and Title: _____ **Date:** _____

Address: _____ **Phone:** _____

Signature/Initials of WIC CPA _____ **WIC Certification Date:** _____ ☐ Mid-cert

Meriden WIC Program
165 Miller Street
Meriden, CT 06450
Ph: (203) 630-4245
Fax: (203) 630-4249

State of Connecticut-Department of Public Health-WIC Program
CERTIFICATION/MEDICAL REFERRAL FORM for WOMEN

Participant ID #: _____ Family ID #: _____

Name _____ **Date of Birth (DOB)** ____/____/____

Address _____ **Phone:** (____) _____

☐ **Pregnant:** _____ **weeks**	**Pre-pregnancy weight:**	***Trimesters 1 & 3: Hgb < 11.0 g/dl; Hct: <33%**
EDD:	**DATE COLLECTED (Wt/Ht):**	**Trimester 2: Hgb < 10.5 g/dl; Hct: <32%**
☐ **Postpartum**	**Weight:** **Height:**	**Non-preg <15 yrs: Hgb < 11.8 g/dl; Hct: <33.7%**
☐ **Breastfeeding**	**DATE COLLECTED (Hgb/Hct):**	**Non-preg 15-17 yrs: Hgb < 12.0 g/dl; Hct: <35.9%**
Actual delivery date:	**Hemoglobin:** **& /or Hematocrit:**	**Non-preg >18 yrs: Hgb < 12.0 g/dl; Hct: <35.7%**
Medications/Medical Problems/Concerns:		

ANTHROPOMETRIC

1. ☐ Pre-pregnancy or postpartum underweight (Body Mass Index-BMI <18.5) _____ **BMI**
2. ☐ Pre-pregnancy or postpartum overweight (BMI ≥ 25) _____ **BMI**
3. ☐ Low maternal weight gain _____ or weight loss _____ during pregnancy
4. ☐ High maternal weight gain

Weight/height measurements must be within 60 days of WIC certification appointment.

BIOCHEMICAL (1998 CDC Standards)

5. ☐ Anemia*
6. ☐ Elevated blood lead level (≥ 5 ug/dl in last 12 months)

CLINICAL/ HEALTH/ MEDICAL

7. ☐ Nutrient deficiency disease. Specify _____
8. ☐ Gastrointestinal disorder. Specify _____
9. ☐ Nutritionally significant genetic or congenital disorder. Specify _____
10. ☐ Nutrition related infectious disease. ☐ Acute ☐ Chronic Specify _____
11. ☐ Nutrition related non-infectious chronic disease. Specify _____ ____/____ mm Hg
12. ☐ Other nutrition related medical conditions. Specify _____
13. ☐ Smoking by a pregnant, breastfeeding or postpartum woman
14. ☐ Alcohol use ☐ or drug abuse ☐ _____
15. ☐ Oral health conditions. Specify _____

OBSTETRICAL:

16. ☐ Hyperemesis gravidarium
17. ☐ Gestational diabetes: presence of ☐; history of ☐
18. ☐ History of diagnosed Preeclampsia (pregnancy-induced hypertension) ____/____ mm Hg (>140mm Hg systolic or > 90mm Hg diastolic)
19. ☐ History of preterm (< 37 weeks gestation) delivery
20. ☐ History of low birth weight (< 5.5 pounds or < 2500 grams) delivery
21. ☐ History of spontaneous abortion (≥ 2), fetal or neonatal death
22. ☐ Age at conception ≤ 15 years _____ or ≤ 17 years _____
23. ☐ Short Interpregnancy interval (<18 months between live births)
24. ☐ High parity and young age
25. ☐ Prenatal care beginning after the first trimester
26. ☐ Multifetal gestation
27. ☐ Fetal Growth Restriction (FGR) (fetal weight < 10th percentile for gestational age)
28. ☐ History of birth of a large for gestational age infant (≥ 9 pounds or ≥ 4000 grams)
29. ☐ History of birth with nutrition-related congenital or birth defect
30. ☐ Pregnant woman currently breastfeeding
31. ☐ Breastfeeding mother of infant at nutritional risk ☐ non-dietary; ☐ dietary
32. ☐ Breastfeeding complications or potential complications. Specify _____

DIETARY (Document in CT-WIC)

33. ☐ Specify code(s) _____

OTHER NUTRITIONAL RISKS

34. ☐ Possible regression in nutritional status if removed from the program ☐ non-dietary; ☐ dietary
35. ☐ Homelessness or migrancy
36. ☐ Other risks. Specify _____

Health Care Provider Signature and Title: _____ **Date:** _____

Address: _____

Signature/Initials of WIC CPA _____ **WIC Certification Date:** _____