Michigan WIC Special Formula/Food Request Form

1. QUALIFYING MEDICAL CONDITION(S):
- □ Premature birth < 37 weeks gestation
- □ Failure to thrive
- □ Severe food allergies (Specify) ____________
- □ Immune system disorder (Specify) ____________
- □ Metabolic disorder/inborn errors of metabolism (Specify) ____________________
- □ Medical condition that impairs nutrition status (Specify) ____________________
- □ Gastrointestinal disorder/malabsorption syndromes (Specify) ________________

Conditions such as rash, non-specific intolerance, underweight, fussiness, colic, spitting-up, vomiting, gas and constipation will NOT be considered indications for a special formula. Please specify the underlying medical condition.

2. FORMULA: __________________ AMOUNT* Needed per Day ________________

*If not specified, up to the WIC maximum allowable may be provided. Maximum allowable may not meet patient's full need.

A list of Michigan Authorized Formulas is available at: www.michigan.gov/WIC Click on Link: Medical Providers

3. SUPPLEMENTAL WIC FOODS: (CHECK ONE; MUST BE COMPLETED FOR ALL FORMULA REQUESTS)
- □ All (Issue all allowed age appropriate WIC Foods starting at six months)
- □ Restriction (Check foods to be OMITTED):
  - Infant (6-12 months)
  - Child (1-5 Years) and Woman
  - Special Instructions/Comments:

  □ Infant cereal
  □ Infant fruits/vegetables
  □ Cheese
  □ Eggs
  □ Legumes
  □ Peanut butter
  □ Breakfast cereal
  □ Bread, rice, tortilla, oatmeal
  □ Fresh fruits/vegetables
  □ 100% fruit/vegetable juice
  □ Canned fish (women only)

4. MILK SUBSTITUTIONS (Optional): MEDICAL REASON FOR MILKFAT CHANGE
- □ 2% milk (in place of: ≤1% milkfat, woman/child ≥ 2 yrs; or whole milk, child 12-23 mo.). Honored only if medically indicated.
- □ Whole milk (in place of ≤1% milkfat, woman/child ≥ 2 yrs): Honored only if medically indicated formula prescribed above.
- □ Soy Beverage in place of milk for child:
  - □ Milk allergy
  - □ Lactose intolerance
  - □ Vegetarian/Vegan diet
  - □ Cultural practice
  - □ Other: ____________

5. DURATION:
- □ 1 month □ 2 months □ 3 months □ 4 months □ 5 months □ 6 months (maximum approval)

<table>
<thead>
<tr>
<th>Medical Provider Name:</th>
<th>WIC Use Only</th>
<th>Client # (Optional)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Address:</td>
<td>Approved Through (Optional):</td>
<td></td>
</tr>
<tr>
<td>Phone:</td>
<td>Reason (If Denied):</td>
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<td>Fax:</td>
<td>Signature (If Denied):</td>
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<td>Date:</td>
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WIC CLINIC: ___________________________ Phone: ___________________________ Fax: ___________________________

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