Fax #: 918-287-5362

Osage Nation WIC Medical Request for Formula/Food

All requests are subject to WIC approval and provisions based on program policy and procedures. Diagnosis provided must support the issuance of the product requested.

Patient Information

Last Name: _____ First Name: _____ DOB: _____

Formula Information

Name of Formula: _____

Requested Length of Issuance: □ 3 months □ 6 months Other: _____

Formula Amount: _____ per day*

*Maximum allowed by federal guidelines will be provided unless lesser amount indicated

Qualifying Diagnosis: _____

Previous Formulas Used: _____

Note: Formulas may not be issued solely for the purpose of enhancing nutrient intake, managing body weight, non-specific formula or food intolerances, preference for a specific formula, or because baby is doing well on a certain formula.

Infants (6-12 months old)

All age appropriate infant foods will be issued with the prescribed formula **unless checked below:**

- ☐ Provide only formula due to inability or delay in consuming solid foods.
- ☐ The foods checked below need to be **OMITTED** from the food package.
  - □ Infant Cereal
  - □ Infant Fruits/Vegetables
  - □ Fresh Fruits/Vegetables (9-11 months)

Children (1-5 years old) and Women

All appropriate WIC foods will be issued with the prescribed formula **unless checked below:**

- ☐ Provide formula only. No supplemental foods.
- ☐ The foods checked below need to be **OMITTED** from the food package.
  - □ Milk □ Eggs □ Cereal
  - □ Cheese □ Legumes □ Whole Grains
  - □ Yogurt □ Peanut Butter □ Juice
  - □ Fruits/Vegetables □ Canned Fish (Fully BF women only)

Milk/Yogurt Substitutions for Children/Women

Medical Reason for Milk Fat Change: _____

☐ 2% milk/low or nonfat yogurt (in place of ≤ 1% milk fat for woman/child ≥ 2 yrs. or whole milk for child 12-23 mo.)
☐ Whole milk/whole yogurt (in place ≤ 1% milk fat for woman/child ≥ 2 yrs.)

Requested Length of Issuance: □ 3 months □ 6 months Other: _____

Required Health Care Provider Information

Signature of Health Care Provider: _____ Date: _____

Provider's Name (print): _____

Phone #: _____ Fax #: _____