**Directions:** Please complete **all higlighted sections** and return this form to the participants WIC Clinic.

**Office #(505) 869-2662, Fax #(505) 869-7571**

**\*All requests are subject to WIC approval and is based on program and policies and procedures**

|  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Required Patient Information** | | | | | | | | | | |
| **Last Name:** | | | | **First Name:** | | | | | **DOB:** | |
| **Parent/Caregiver’s Name:** | | | | | | | | | | |
| **Qualifying Condition/Diagnosis/ICD-10 Code: (Check Below)** | | | | | | | | | | |
| Allergy, confirmed [cow’s milk protein, soy] (L.27.2) 353 | | | | | | Failure to Thrive (C-R62.51, W-R62.7) 134 | | | | |
| Congenital Anomaly, Respiratory (Q34.9) 360 | | | | | | Intestinal Malabsorption (K90.0) 342 | | | | |
| Developmental Sensory/Motor Delays (R62.50) 362 | | | | | | Low Birth Weight (P07.10) 141 | | | | |
| Gastroesophageal Reflux (K21.9) 342 | | | | | | Metabolic Disorders (E88.9) 351 | | | | |
| Inadequate Growth (R62.50) 135 | | | | | | Other/(w/ICD 10): | | | | |
| Lactose Intolerance (E73.9) 355 | | | | | |  | | | | |
| Low Maternal Weight Gain (O26.11-13) 131 | | | | | |  | | | | |
| Underweight (R63.6) 101 or 103 | | | | | |  | | | | |
| **\*\*NOT ALLOWED: Constipation, diarrhea, unconfirmed allergies, managing body weight, lactose intolerance symptoms, or growth concerns UNLESS there is an underlying medical condition.** | | | | | | | | | | |
| **Measurements** | | | | | | | | | | |
| Date: | Length/Height: | Weight: | | | If Premature, Birth Weight: | | Weeks’ Gestation: | | | |
| **Name of Formula(s)** (If not marked on reverse side) | | | | | | | | | | |
|  | | | | | | | | | | |
| **Requested Length of Issuance**  \*\*Maximum allowed by federal guidelines of 6 months will be issued unless otherwise indicated. | | | | | | | | | | |
| **1 Month 3 Months 6 Months**  **Formula Amount \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_per day\*** | | | | | | | | | | |
| **Infants (6-12 Months Old)** | | | | | **Children (1-5 Years Old) and Women** | | | | | |
| Full amount of formula and infant foods will be given ***unless*** checked below. | | | | | All appropriate WIC foods, will be issued with a prescribed formula ***unless***checked below. | | | | | |
| Provide only formula past 6 months of age due to inability or delay in consuming solid foods.  **Check WIC Supplemental Food to OMIT at 6 months of age**   |  |  | | --- | --- | | Infant Cereal | Baby Food  (Fruit and/or Vegetables) | | | | | | For Milk Allergy: Formula or other:  Indicate: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Provide **infant foods** for cash value fruits and vegetables  No supplemental foods, provide formula ONLY  **Check WIC Supplemental Foods to OMIT from Food Package**   |  |  |  |  | | --- | --- | --- | --- | | Dairy | Peanut Butter | Cereal | Juice | | Eggs | Beans | Whole Grains | Fruits/Veg | | | | | | |
| **Required Health Care Provider Information** | | | | | | | | | | |
| Signature/Stamp of Health Care Provider (MD/DO/PA/CNP): | | | | | | | | | | Date: |
| Provider Name (Please Print): | | | Phone #: | | | | | Fax #: | | |

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| --- | --- |
| **Special Formula RX REQUIRED** | |
| Alimentum Powder 12.1 oz | Similac Advance RTF 32 oz |
| Alimentum RTF 32 oz | Similac PM 60/40 Powder Low Iron 14.1 oz |
| Boost Kid Essentials 1.5 cal | Similac Pro-Advance\* |
| Boost Kid Essentials 1.5 cal w/ fiber | Similac Pro-Sensitive\* |
| Boost Plus RTF 8oz BTL - 6PK | Similac Soy Isomil RTF 32 oz |
| Elecare Powder 14.1 oz | Similac Pro-Total Comfort\* |
| Enfamil A.R. Lipil Powder 12.9 oz | Similac Sensitive RTF 32 oz |
| Enfamil Gentlease Powder 12.4 oz | Similac 360 Total Care Powder\* |
| Enfamil Gentlease RTU 32oz | Similac 360 Total Care Sensitive 8 oz RTF |
| Enfamil Infant Concentrate 13oz | Similac 360 Total Care Sensitive 32 oz RTF |
| Enfamil Infant Powder 12.5 oz | Similac 360 Total Care 8 oz RTF |
| Enfamil Infant RTU 32 oz | Similac 360 Total Care 32 oz RTF |
| Enfamil Lipil 24 cal 2 oz |  |
| Enfamil Lipil AR RTU 32 oz | **No RX is required for infants under 12 months for the formulas listed below:** |
| Enfamil Neuropro Infant Powder\* | Similac Advance Powder 12.4 oz |
| Enfamil Neuropro Infant RTF 32 oz | Similac Advance w/Iron Concentrate 13 oz |
| Enfamil Neuropro Enfacare Powder 13.6 oz | Similac Sensitive Powder 12.5 oz |
| Enfamil Neuropro Gentlease Powder\* | Similac Soy Isomil Powder 12.4 oz |
| Enfamil Neuropro Gentlease RTF 32 oz | Similac Soy Isomil Concentrate 13 oz |
| Enfamil Neuropro Sensitive Powder\* | Similac Total Comfort Powder 12.6 oz |
| Enfamil Premature Lipil 24 cal 2 oz |  |
| Enfamil Prosobee Lipil Concentrate 13 oz | \***If you need a formula not listed here, please call our office.** |
| Enfamil Prosobee Lipil Powder 12.9 oz |  |
| Enfamil Prosobee Lipil w/iron RTU 32 oz | \*Formula Sizes may vary. |
| Enfamil Reguline 12.4 oz Powder |  |
| Ensure RTF 8 oz | Available formulas are subject to change. Please visit <https://www.isletapueblo.com/tribal-programs/wic-woman-infants-children/> for current version of this form. Scroll down to additional resources at bottom of page and click on Isleta WIC Medical Request for Formula/Food Form |
| Ensure w/Fiber RTF 8 oz |  |
| Gerber Good Start Gentle Powder\* |  |
| Gerber Good Start GentlePro Powder \* |  |
| Gerber Good Start SoothePro Powder \* |  |
| Gerber Good Start Soy Powder \* |  |
| Neocate DHA/ARA Powder 14.1 oz |  |
| Neocate Jr Powder 400g |  |
| Neocate Powder 14 oz |  |
| Neosure Powder 13.1 oz |  |
| Neosure RTF 32 oz |  |
| Nutramigen Lipil Concentrate 13 oz |  |
| Nutramigen Lipil RTF 32 oz |  |
| Nutramigen Lipil w/Enflora LGG 12.6 oz |  |
| Pediasure RTF 8oz |  |
| Pediasure w/Fiber RTF 8 oz |  |
| Peptamen Jr RTF 8.45 oz |  |
| Progestimil Lipil Powder 16 oz |  |