Knox County
Health Department
Every Person, A Healthy Person

WIC (WOMEN, INFANTS, AND CHILDREN) PROGRAM
MEDICAL DOCUMENTATION FORM

THIS FORM MUST BE COMPLETED BY HEALTH CARE PROVIDER.

1. PATIENT INFORMATION

Patient name: _____ Patient date of birth: _____/_____/_____

Participant medical data:	Weight: _____	Height/length: _____	Hgb: _____ Hct: _____
Date measured:	_____/_____/_____	_____/_____/_____	_____/_____/_____

☐**Yes** ☐**No** **This child receives ongoing health care from my practice. If "No," child must be present at WIC visit.**

2. FORMULA REQUEST

Formula requested: _____ Dilution strength (if greater than standard for product): _____
Amount per 24 hours: ☐Maximum allowed _____ oz./day Tube fed: ☐Yes ☐No
Requested length of issuance: ☐1 month ☐2 months ☐3 months ☐4 months ☐5 months ☐6 months ☐12 months
Note: If no length specified, WIC will provide up to 6 months for therapeutic formulas and up to 12 months for alternate contract formulas.

3. QUALIFYING CONDITION (Qualifying condition not necessary for alternate contract products)

Nutrition-related **WIC Qualifying Condition:** _____
Clinical findings, laboratory results, diagnostic evidence of need:
_____
REQUEST IS SUBJECT TO TN WIC APPROVAL. PROVISION IS BASED ON PROGRAM REGULATION AND POLICY.

4. WIC SUPPLEMENTAL FOODS

My signature below authorizes the Tennessee WIC nutrition staff to determine appropriate WIC supplemental foods, amounts, and length of issuance for the participant.

☐**WIC nutrition staff** to determine appropriate WIC foods to provide.
☐**Provide** age appropriate WIC foods. **Exceptions (specify):** _____
☐**Omit** all supplemental foods, and provide medical formula only.
☐For child (age 1-4) with qualifying condition, provide infant fruits/vegetables.
☐Provide whole milk/yogurt. Only patients with a qualifying condition who need additional calories may receive whole milk/yogurt.

5. HEALTH CARE PROVIDER INFORMATION

Signature of HCP: _____ Date: _____/_____/____
Provider's name: _____
Office address: _____
Phone: _____ Fax: _____

INSTRUCTIONS FOR USE

1. Health care provider must complete Section 1. Include hemoglobin/hematocrit if utilizing this form for referral measures. Measures must be completed within 60 days of WIC visit unless requesting a therapeutic product. In this case, measures must be completed within 30 days.
2. If requesting any formula or nutritional product, complete all components in Section 2. The Tennessee WIC Formulary is found online at http://tn.gov/assets/entities/health/attachments/TN_WIC_Formulary.pdf.
3. If requesting a non-contract, therapeutic product, complete Section 3 in addition to Section 2. The list of WIC Qualifying Conditions is available online at http://www.tn.gov/assets/entities/health/attachments/Tennessee's_Nutrition_Related_WIC_Qualifying_Conditions.pdf.
4. If patient has any dietary restrictions or needs a different WIC food package, describe in Section 4.
5. Health care provider must complete Section 5 and sign.

WIC Use Only: _____