

Texas WIC Medical Request for Metabolic Formula/Food

All requests are subject to WIC approval and provision based on program policy and procedure

A. Required Patient Information

Patient's Last Name: _____ First Name: _____ DOB: _____

Parent/Caregiver's Name: _____

Qualifying Condition/Diagnosis: _____

Measurements

Date: _____ Length/Height: _____ Weight: _____ If premature: Birth weight: _____ Weeks Gestation: _____

B. Formula and WIC Supplemental Foods

Requested length of issuance: 3 months 6 months Other:

Name of Formula(s)	Amount per Day	Unit Size	Units per Month

WIC Supplemental Foods (at 6 months of age) – for Infant

Unless indicated below, all supplemental foods will be provided. The RD/Nutritionist can determine the appropriate supplemental foods and amounts if left blank.

___ Formula only (no foods and increased amount of formula past 6 months of age due to inability or delay in consuming solids).

___ Omit – The foods indicated here need to be omitted from my patients' WIC Food Package: Infant Cereal Baby Foods

Special Instructions or Comments:

WIC Supplemental Foods – Children

Unless indicated below, all supplemental foods will be provided. The RD/Nutritionist can determine the appropriate supplemental foods and amounts if left blank.

___ Provide milk in addition to formula

___ None – Do not provide supplemental foods at this time; issue medical formula only

___ Omit – The foods indicated below need to be omitted from my patient's WIC food package:

Eggs Juice Peanut Butter Cheese Whole Grains Cereal Beans Fruits and Vegetables

___ Provide baby foods due to medical condition and inability to consume table foods

C. Required Health Care Provider (HCP) Information

([List of Approved Metabolic Centers](https://dshs.texas.gov/newborn-screening-program/clinical-care-coordination-consultants) - dshs.texas.gov/newborn-screening-program/clinical-care-coordination-consultants)

Metabolic Nutritionist Name: _____ Phone No.: _____

Metabolic Center: _____ Phone No.: _____

Frequency of Contact: Monthly Quarterly Other

Signature/Stamp of HCP (MD, DO, PA, NP): _____ Date: _____

Provider's Name (Please Print): _____ Individual NPI: _____

Phone No.: _____ Fax No.: _____



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Phone: () _____

Fax: () _____