PRINT Download Clear Form

GUAM WIC PROGRAM
SPECIAL FORMULA REQUEST

[To be completed by Physician, Physicians' Assistant, or Nurse Practitioner]

Dear Healthcare provider,

The **Guam WIC Program** provides only Enfamil with iron infant formula for non-breast fed infants. When the need for an alternate formula is indicated due to a serious medical condition, a special or non-contract infant formula may be requested. Complete this form so that the request can be evaluated by our nutrition staff. Be sure that a physician's diagnosis for the medical problem(s) requiring a special or non-contract infant formula is indicated and signed by a Physician, Physician's Assistant, or Nurse Practitioner so that program requirements for documentation of the medical need will be met for the issuance of the requested formula.

THE WIC PROGRAM AND TAXPAYERS PAY SIGNIFICANTLY MORE PER MONTH FOR NON-CONTRACT AND SPECIAL INFANT FORMULAS.

By completing and signing this form you are verifying to the **WIC Program** that :

1. You have seen this infant or child and evaluated the feeding practices and any related physical/medical symptoms.
2. This infant or child has tried Enfamil with iron infant formula for at least 7 days unless medically contraindicated.
3. The medical condition identified precludes the use of Enfamil with iron. General symptoms such as fussiness, colic, spitting up, constipation, etc. will not be accepted as a medial diagnosis for justification of a special or non-contract formula.
4. You are aware that for this request to be accepted by the **WIC Program**, the prescriptive authority must indicate at least one medical diagnosis and sign on the appropriate lines below.
5. You are aware that the requested formula will be provided for only one month. After one month the infant or child will be re-challenged with Enfamil with iron for at least seven days unless medically contraindicated.
6. You understand that clients will be told to work with their physicians as well as our Nutritionist to complete the re-challenge.

The above has been acknowledged. Initial: _____ **Date:** _____
(Healthcare Provider)

Thank you for your assistance in eliminating unnecessary formula substitutions. With your help, we can maximize the number of deserving WIC clients enrolled in the program.

The WIC Program supports breast feeding as the optimal method of feeding infants. If you are interested in hearing more about WIC's breast feeding promotion program, want to coordinate your breast feeding efforts with WIC, or have ideas on how WIC can further promote breast feeding, please call the GUAM WIC PROGRAM at 475-0290.

THE FOLLOWING INFORMATION WILL ASSIST THE WIC NUTRITIONIST IN DETERMINING WHETHER OR NOT THE CRITERIA HAVE BEEN MET FOR ISSUING AN INFANT FORMULA OTHER THAN THE STANDARD CONTRACT FORMULA DISTRIBUTED BY THE GUAM WIC PROGRAM

Child's Name: _____ Parent's/Guardian's Name: _____

1. **Formulas tried:** (include Enfamil with iron if used)

a. Name of formula: _____ Result:

Date started: _____ Date ended: _____

b. Name of formula: _____ Result:

Date started: _____ Date ended: _____

c. Name of formula: _____ Result:

Date started: _____ Date ended: _____

[ ] Medically contraindicated for infant to try other formulas. **Explain:**

2. **Diagnosis (original signature required below):**

a. Complications of prematurity (up to 3 months of age only). Medical Diagnosis of condition:

b. Chronic lung disease or asthma. **Medical Diagnosis of condition:**

c. Failure to thrive. **Medical Diagnosis of condition:**

d. Organic heart disease. **Medical Diagnosis of condition:**

e. Allergy or anaphylactic shock secondary to formula intolerance. **Medical Diagnosis of condition:**

f. Severe gastrointestinal disorders. Medical Diagnosis of condition:

g. Iron storage diseases such as Thalassemia (low iron formulas limited to this diagnosis). **Medical Diagnosis of condition:**

h. Severe chronic/persistent diarrhea or vomiting secondary to formula intolerance. **Medical Diagnosis of condition:**

3. Formula requested: _____ **Date formula requested:** _____ **Anticipated duration of use:** _____

Special feeding instructions:

4. Signature of Healthcare provider: _____

Please print name, address and contact number of healthcare provider:

FOR WIC OFFICE USE ONLY: Date: _____ Special formula requested: _____ Request Approved: ___ Denied: ___
Reason for disapproval: Incomplete form: ___ Dx does not meet WIC criteria: ___ Other (explain):

Signature of WIC Nutritionist: _____