

**Mississippi State Department of Health - WIC Program  
Request for Medical Formula for Women or Children (≥ 1 yr.)**

This request must be completed with the signature of the physician or licensed medical professional with prescriptive authority under State law\*. The request should be no more than 60 days old when received by the WIC clinic. The request is subject to WIC approval and provision based on program policy and procedure.

Patient's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Weight: \_\_\_\_\_ Height: \_\_\_\_\_ Date of Measurements: \_\_\_\_\_

Medical Diagnosis/Qualifying Condition (justifying need for medical formula):  
\_\_\_\_\_  
\_\_\_\_\_

Medical formula/food requested: \_\_\_\_\_

Prescribed amount of medical formula per day: \_\_\_\_\_

Is child tube fed?  Yes  No

Duration of time requested (maximum 3 month period): \_\_\_\_\_

**Oral Intake Evaluation**

**Must be completed by authorized medical professional\***

WIC supplemental foods may be provided based on medical diagnosis and oral intake evaluation. Please assist us in determining appropriate WIC foods for this participant.

Formula only

Place a (✓) by the WIC supplemental foods this participant should NOT be offered:

- Infant Cereal
- Milk
- Cheese
- Eggs
- Cereal (Adult/Child)
- Bread/Brown Rice/Tortillas
- Fruits and Vegetables (Fresh and/or Canned)
- Fruit Juice
- Beans/Peas
- Peanut Butter
- Tuna (Breastfeeding Women Only)

\_\_\_\_\_  
Signature of Physician/Authorized Medical Professional\*

\_\_\_\_\_  
Date

**Mississippi State Department of Health – WIC Program**  
**Request for Medical Formula for Women or Children (≥ 1 year)**  
**Form No. 263**

**Purpose:** This form should be completed by a physician or licensed healthcare provider to provide medical documentation/justification when requesting issuance of a medical formula to a woman or child eligible for WIC services.

**Instructions:**

Record patient's first and last name and date of birth.

Record patient's weight, height and date of measurements.

Document the medical diagnosis or condition that justifies the need for medical formula.

Document the name of the medical formula/food requested.

Document the amount of the medical formula/food prescribed for the patient per day.

Place a  $\checkmark$  in the box beside "yes" or "no" to indicate if the patient is tube fed.

Document the duration of time the medical formula/food is being requested.

An oral intake evaluation (in text box) must be completed by the medical provider or the WIC certifier. The medical provider can place a  $\checkmark$  in the box to request the WIC certifier to assess for intake of appropriate medical foods or to indicate that no supplement foods should be offered.

The medical provider or WIC certifier should place a  $\checkmark$  by the supplemental foods listed available through WIC that are appropriate for the participant to be offered.

The individual completing the oral intake evaluation should sign on the bottom line in the text box.

The physician or licensed healthcare provider requesting the medical formula or food must sign on the line at the bottom of the page.

**Office Mechanics and Filing**

This form becomes part of the patient's medical record.

**Retention Period**

Retain according to patient retention policy for that record type.