SOUTH CAROLINA WIC PROGRAM
MEDICAL DOCUMENTATION FOR WIC SPECIAL FORMULA AND FOODS

- ***Health Departments may order approved Special Formulas (not contract formulas) and could take up to 7+ days for delivery. Approved formula list found at www.scdhec.gov/wic***
- ***Prescription is subject to WIC approval based on program policy and procedure.***

Participant's Name: Date of Birth:

1. Medical Condition(s)

Medical Diagnosis- Select all that apply, write specifics when indicated in the blank space provided

____ Failure to Thrive(R62) ____ GERD(K21) ____ Malabsorption (specify)(K90)_____
____ Cystic Fibrosis(E84) ____ Cow's Milk Protein Allergy(Z9.011) ____ Metabolic Disorder (specify)(E88)_____
____ Down Syndrome(Q90) ____ Prematurity/Low Birth Weight(P07.1) ____ Heart/circulatory (specify)(I99)_____
____ Developmental Delay(R62.5) ____ Food allergy (specify)(Z91.01)_____ ____ Other (specify) _____
____ Cerebral Palsy(G80) ____ Feeding Tube (specify)(Z93.1)_____

Not acceptable WIC Medical diagnosis: Spitting up, milk/formula intolerance, picky eater, constipation, fussiness or gas

For Enfamil AR consideration, two (2) medical diagnoses must be documented. One diagnosis must be GERD and the other must be one of the following conditions.

- History of GERD surgery (ex. Fundoplication)
- Failure to thrive, weight loss, or inadequate weight gain
- Other related medical condition (specify above)
- Frequent pneumonia

2. Anthropometric Data (Within 30 days)

Weight _____ lb. _____ oz. Height _____ Inches *Required for weight-related medical diagnoses

Head Circumference_____ Inches Hgb/Hct_____ Date Taken_____

3. Formula

Formula Name:	Amount: _____ oz./day _____ Cans or packets/ day _____ Max. issuance
Length of Use _____ 1 mo. _____ 2 mos. _____ 3 mos. _____ 4 mos. _____ 5 mos. _____ 6 mos.	Form: _____ Powder _____ Concentrate _____ Ready to feed

Special Instructions:

4. Supplemental Foods

- Foods will be issued at the maximum allowable amounts at 6 months of age unless otherwise indicated

Option 1: _____ Supplemental foods are contraindicated at this time. Provide formula only.
Option 2: _____ Healthcare Provider to select appropriate foods below.
Option 3: _____ Refer to a WIC Registered Dietitian for food selections

Infants	____ No Infant Cereal ____ No Baby Food Fruits and Vegetables
Children & Women	____ No Milk ____ No Cheese ____ No Breakfast Cereal ____ No Beans ____ No Peanut butter ____ No Eggs ____ No Fish ____ No Juice ____ No Fruit/Vegetables ____ No whole wheat bread or whole grain substitute ____ Provide infant foods and cereal ____ Other (specify):_____

5. Provider Information (Complete All Boxes)

Signature of Provider Date

Approval Signature Date

Provider's Name (Print)

Office Name

Address

City State Zip Code

Phone Number Fax Number

WIC USE ONLY

Participant ID #

Name

DOB

This institution is an equal opportunity provider.

South Carolina WIC Program
Medical Documentation for WIC Approved Special Formula and WIC Approved Foodsfor Women, Infants & Children
(Instructions for Completing DHEC 2074)

PURPOSE: To use when issuing a prescription for WIC approved special formula and foods.
EXPLANATION AND DEFINITION: This form is completed by the healthcare professional licensed to write medical prescriptions under SC state law for WIC participants with special dietary needs.

ITEM-BY-ITEM INSTRUCTIONS:
Participant's Name: Enter name of the participant.
Date-of-Birth: Enter participant's birth date.
Medical Condition(s): Place check (√) beside one or more of the medical condition(s) or check (√) "other" and write the medical diagnosis. When "specify" is indicated, write comments in the space provided.
Note: Symptoms such as spitting up, milk/formula intolerance, picky eater, constipation, cramps, fussiness, or gas are not considered acceptable medical conditions and will not be approved by WIC or issuance of a special formula. WIC will not provide formula to enhance nutrient intake or manage body weight without an underlying medical condition.
Enfamil AR: **Two (2) medical conditions must be documented** and supported with anthropometric data for added rice starch infant formulas to be issued. **One condition must be GERD and the second condition must be a medically related condition.**
Current Data: Enter weight, length/height, head circumference, hgb/hct. Enter date taken.
Formula: Enter prescribed WIC formula.
Amount: Enter amount ounces per day or cans or packets/day or check (√) "maximum issuance"
Length-of-use: Place a check (√) beside the time period. **Prescription not to exceed 6 months. Exception: Metabolic formula prescription not to exceed 1 year.**
Form: Place a check (√) beside form type.
Special Instructions: Enter any special instructions or comments.
Supplemental foods: **Foods will be issued at 6 months, unless otherwise indicated. Check (√) option to specify. Option 1: Formula Only Option 2: Healthcare Provider Option 3: WIC RD selects**
Infants: Select options for modified food package.
Children: Select options for modified food package.
Healthcare Provider: Enter signature and credentials.
Date: Enter date prescription written.
Provider's Name: Enter printed name of healthcare provider. May stamp contact information.
Office Information: Enter office name, address, city, zip code, telephone number, and fax number.
WIC RD/CPA Approval Signature: Signature of RD/CPA
Date: Enter date of formula approval
Participant ID number: Participant ID number

Children	**Pregnant or Partially Breastfeeding Women**	**Fully Breastfeeding**	**Non-Breastfeeding/Postpartum Women**
Up to 910 fl. oz. reconstituted formula	**Up to 910 fl. oz. reconstituted formula**	**Up to 910 fl. oz. reconstituted formula**	**Up to 910 fl. oz. reconstituted formula**
16 quarts milk 1 lb. cheese may be substituted for 3 qts. 1 quart yogurt may be substituted for 1 quart of milk.	22 quarts milk 1 lb. cheese may be substituted for 3 qts. 1 quart yogurt may be substituted for 1 quart of milk	24 quarts milk 1 lb. of cheese 1 quart yogurt may be substituted for 1 quart of milk.	16 quarts milk 1 lb. cheese may be substituted for 3 qts. 1 quart yogurt may be substituted for 1 quart of milk.
1 dozen eggs	1 dozen eggs	2 dozen eggs	1 dozen eggs
36 oz. cereal	36 oz. cereal	36 oz. cereal	36 oz. cereal
2 lb. whole wheat bread or substitute	1 lb. whole wheat bread or substitute	1 lb. whole wheat bread or substitute	N/A
18 oz. peanut butter (> 2 years only) OR 1 lb. dried peas/beans	18 oz. peanut butter AND 1 lb. dried peas/ beans	18 oz. peanut butter AND 1 lb. dried peas/beans	18 oz. peanut butter OR 1 lb. dried peas/beans
128 ounces juice	144 ounces juice	144 ounces juice	96 ounces juice
$9.00 Cash Value Voucher for fruit and vegetables	$11.00 Cash Value Voucher for fruit and vegetables	$11.00 Cash Value Voucher for fruit and vegetables	$11.00 Cash Value Voucher for fruit and vegetables
N/A	N/A	30 ounces canned fish	N/A
Infants	**Infants 0-3 months***	**Infants 4-5 months***	**Infants 6-11 months***
Formula Concentrate - reconstituted	806 fluid ounces	884 fluid ounces	624 fluid ounces
Foods Full Formula or Partial Breastfeeding	N/A	N/A	32- 4 oz. containers infant fruits & vegetables 24 oz. infant cereals 9-11 months old- Optional FRESH ONLY $4 Cash Value Voucher with 16- 4 oz. infant fruits & vegetable
Foods Fully Breastfeeding	N/A	N/A	64- 4 oz. containers infant fruits & vegetables 24 oz. infant cereals 31- 2.5 oz. infant meat 9-11 months old- Optional FRESH ONLY $8 Cash Value Voucher with 32- 4 oz. infant fruits & vegetable

*Formula quantities provided are less if the infant is breastfeeding

Office Mechanics and Filling: This form should be scanned in SCWIC under Communication for the participant.