# NAVAJO NATION WIC FORMULA/FOOD AUTHORIZATION FORM
## FOR PREMATURE AND MEDICALLY FRAGILE INFANTS

Client Name:________________________________ID#____________________________Clinic______________________

Date of Birth: ____________________WIC Staff:________________________ Clinic Site:__________________________

***Please fully complete every section (1-7) to avoid delays in issuance.***

*Please choose WIC contract formulas whenever possible, noted by (*)*

1. ***WIC CONTRACT FORMULAS:*** ☐ Similac Advance * (*8oz RTF, 19kcal, for Women & Children only*)
   ☐ Gerber Goodstart Soy *

***OR***

***WIC NON-CONTRACT FORMULAS REQUIRING A PRESCRIPTION***:

☐ ***Enfamil Prosobee*** ☐ ***Similac for Spit-Up*** *(19 kcal)* ☐ ***Enfamil Enfacare, 22 kcal***
☐ ***Similac Soy Isomil*** ☐ ***Similac Expert Care NeoSure, 22kcal*** ☐ ***Enfamil Premature,24 kcal***
☐ ***Similac Special Care w/iron, 20 kcal RTF*** ☐ ***Similac Special Care w/ iron, 24 kcal RTF***
☐ ***Similac Sensitive for Fussiness & Gas*** *(19 kcal)* ☐ ***Alimentum*** ___________________________*(specify type)*
☐ ***Nutramigen*** _________________________*(specify type)* ☐ ***Pediasure*** ____________________________*(specify type)*
☐ ***Other Special Formula:***______________________________________________________________________

*Note: WIC **does not** authorize low iron formulas.*

2. **Form of Formula to Be Issued:** ☐ Powder ☐ Concentrate ☐ Ready-to-feed
   *Note: Ready to feed form given to premature clients unless otherwise specified.*

3. **Amount of Formula Requested Per Day:** __________________________________ ☐ Orally ☐ Tube Feeding
   *(Ad lib is an acceptable response)*

4. **Diagnosis for Special Formula:** ☐ **Prematurity** ☐ **GERD or reflux** ☐ **Dysphagia** ☐ **Food allergy:** ________________
   ☐ **Failure to thrive (<5th percentile wt/length)** ☐ **Other:**_____________________________________________
   *Note: Must be a specific medical diagnosis.*

5. **Length of Time Formula is Needed:** # months (circle): 1 2 3 4 5 6 (*Formula Rx needs to be renewed every six months*)

6. **WIC Food Restrictions:** Infants 6-11 months will receive the following foods in addition to the formula prescribed (above). Infants<6 mos will **NOT** receive foods. Please check any foods listed below that are **NOT** appropriate for the diagnosis.

   ☐ **Approval for WIC Nutritionist to identify appropriate supplemental foods and prescribe amounts.**

**OR**

   ☐ **All foods are appropriate for the client.**

**OR**

| **WIC Foods** | **Do Not Give** | **Comments**: |
|---|---|---|
| Infant cereal | ☐ | ______________________________________________________ |
| Infant Fruits & Vegetables | ☐ | ______________________________________________________ |

7. **Provider Name and Title:** ________________________________________________ **Date:** _________________

   **Healthcare Provider Signature:** ______________________________________________**Phone #:**________________

   **Medical / Office Name and Address:** __________________________________________________________________

   ___________________________________________________________________________________________________

## Local Nutritionist's Review:

**Length of Authorization: From**______________________ **To** ______________________☐ Approved ☐ Not Approved

**Nutritionist's Signature:**______________________________________________ **Date:**________________________