New Hampshire WIC Program

NEW HAMPSHIRE

1-800-WIC-4321

19 Calorie Formula Medical Documentation Form for *Similac Sensitive*, *Total Comfort*, and *Spit-Up*

The NH WIC Program standard milk and soy-based contract formulas for healthy term babies is **Abbott's *Similac Advance* and *Similac Soy Isomil.*** In addition, ***Similac Sensitive*, *Total Comfort*** and ***Spit-Up*** are alternate standard formula options available however, they require medical documentation, as the caloric density is 19 calories per ounce. Please complete this form below to allow your patient to receive these formulas from the NH WIC Program.

Patient Name:_____ **Date of Birth:**_____

Parent/Caregiver's Name: _____

I authorize my infant's healthcare provider and NH WIC staff to disclose/discuss information regarding this request. I understand that I may change my mind and cancel this permission at any time with my written request to my healthcare provider and that it will not affect my WIC eligibility.

Parent/Caregiver Signature: _____ Printed Name: _____ Date: _____

Please complete the following (check and fill as appropriate):

1.) ❑ Similac Sensitive, Total Comfort **and/or** Spit-Up **19 kcal/ounce formula may be provided for intolerance or GI upset**
*If only one of the listed 19 kcal formulas may be provided, please indicate that formula here:
_____

2.) ❑ **Provide Maximum Allowable** **OR** _____**per day**
(If not specified, up to the maximum allowable may be provided.)

3.) ❑ **Provide this formula until 1 year of age** ❑ **Other:** _____
(If not specified, up to 1st birthday may be provided.)

4.) **I authorize the NH WIC nutritionist, at 6 to 12 months of age, to determine appropriate WIC supplemental foods, amounts, and length of issuance required for the participant.**

❑ I do not agree with the statement above, omit the WIC foods I have checked below.

❑ **Infant cereal** ❑ **Infant fruits** ❑ **Infant vegetables** ❑ **Infant meats**

5.) Additional special Instructions/restrictions if applicable:

6.) **Signature of Health Care Provider:** _____ ❑MD ❑DO ❑NP ❑PA
Provider's Name: (*please print or stamp)*_____
Medical office/clinic: _____
Phone #:_____ **Fax #:** _____ **Date:** _____

7.) Return form to WIC Agency: _____Fax #:_____

WIC USE ONLY: Approved by/date:

Formula request forms are available at http://www.dhhs.nh.gov/dphs/nhp/wic **Revised 07/26/2018**