Pediatric Referral

WIC Agency: PHFE-WIC Program
Therapeutic Formula Fax: 626 200-4264

SECTION I: ***Complete this section to assist the patient with WIC eligibility, WIC services, and appropriate referrals. Whenever a therapeutic formula is prescribed, complete both Sections I and II.***

PATIENT NAME: (First) (Last)				DATE OF BIRTH:
CURRENT HEIGHT/LENGTH: (within 60 days) inches	CURRENT WEIGHT: (within 60 days) lbs oz	CURRENT BMI: (within 60 days) BMI percentile: %	MEASUREMENT DATE:	BIRTH WEIGHT / LENGTH: lbs oz / inches

HEMOGLOBIN OR HEMATOCRIT TEST is required every 12 months when normal and every 6 months when abnormal.

Hemoglobin (gm/dl) or Hematocrit (%)	Lab Result Date

LEAD TEST (recommended at 1–2 years of age): ________ mcg/dL

IMMUNIZATIONS are up-to-date:
☐ Yes ☐ No ☐ Not available

BREASTFEEDING ASSESSMENT (birth to 12 months):
☐ Fully breastfeeding ☐ Never breastfed ☐ Feeding breastmilk & formula ☐ Discontinued breastfeeding (Date:________________)

SECTION II: ***Complete ALL boxes below when therapeutic formula is prescribed. Incomplete information may delay issuance of WIC foods.***

DIAGNOSIS:

☐ Prematurity ☐ GERD or reflux ☐ Food allergy: ________________ (Please specify)
☐ Failure to thrive ☐ Dysphagia ☐ Other: ________________

FORMULA / MEDICAL FOOD: ________________________________

DURATION:__________months **AMOUNT:**____________________oz / day

This prescription is: ☐ New ☐ Refill

NOTE: At 1 year of age, the patient will receive 13 quarts of cow's milk in addition to therapeutic formula unless *Do Not Give* is checked for cow's milk (see WIC Food Restrictions).

COMMENTS:

WIC FOOD RESTRICTIONS: The patient will receive WIC foods in addition to the formula prescribed. Please check all foods listed below that are NOT appropriate for the diagnosis.

No food restrictions

Category	WIC Foods	Do Not Give	Restriction / Comment
Infants (6–12 mo)	Baby cereal		
	Baby fruit / vegetable		
	Fresh fruit / vegetable (9-12 mo only)		
Children (1–5 yr)	Cow's milk / Cheese / Yogurt		
	Eggs		
	Peanut butter		
	Whole grains *		
	Cereal		
	Beans		
	Vegetables / fruits		
	Juice		

*** whole wheat bread, corn/wheat tortilla, brown rice, whole wheat pasta, barley, bulgur, or oatmeal**

HEALTH COVERAGE: ***Refer patient to their health plan or Medi-Cal for a medically necessary formula or medical food.***
WIC only provides these products when they are NOT a covered benefit by the patient's health plan or by Medi-Cal.

Provide patient's health insurance information:	Check action taken:
Private insurance: ________ Medi-Cal managed care: ________ Other: ________	☐ Submitted justification to health plan
Regular Medi-Cal (fee-for-service): ☐ Yes ☐ No	☐ Submitted justification to pharmacist

If the patient requires a therapeutic formula and does NOT have health insurance, check ALL boxes below that apply:

☐ Gave formula samples
☐ Referred to Medi-Cal
☐ Referred to WIC

QUESTIONS: 1-888-942-2229
Health Professionals: Go to www.wicworks.ca.gov; click Health Care Professionals; then click WIC contacts for MDs.

COMMENTS:

NAME – MD, PA or NP	SIGNATURE - MD, PA or NP		MEDICAL OFFICE / CLINIC NAME AND LOCATION OR OFFICE STAMP
PHONE NUMBER		TODAY'S DATE	

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Instructions for Health Care Providers:
Pediatric Referral Form

Medical documentation by a health care provider is required for infants and children with special dietary needs before the WIC Program can issue WIC allowed foods.

This form must be completed by the health care provider (MD, PA, or NP) for:

- **infants and children** who require **therapeutic formula** (even when the therapeutic formula is provided by Medi-Cal or Medi-Cal Managed Care)
- **children** one year and older who require **standard formula provided by WIC**

For infants and children requiring therapeutic formula, and for children (1 – 5 yrs) requiring standard formula: Please complete Sections I and II

Please pay special attention to the following in **Section II:**

- **Diagnosis:** Indicate the qualifying medical condition.
- **Medically Necessary Formula:** Specify the full name of the formula, the duration of use (in months) and the amount per day (in ounces). ***This section needs to be completed even if the patient will receive formula approved by health plan and provided through a pharmacy.***
- **Type of coverage:** WIC federal regulations require that therapeutic formula be provided by Medi-Cal or Medi-Cal Managed Care. Indicate the **name of health plan** and **date of action** taken.
- **Food Restrictions:** Indicate 'No food restrictions', or check any foods, according to the patient's age, that should **NOT** be issued due to the patient's medical condition. This section must be completed for the patient to receive foods from WIC.

Please contact the PHFE-WIC Program at (626) 856-6618 x455
with your questions about completing this form.

Policy:

Therapeutic formulas are not mandated by federal WIC regulations, and the WIC Program provides these formulas based on available funding and secondary to payment by a Medi-Cal or Medi-Cal Managed Care..

The WIC Program retains the authority to determine which formulas are available to participants.

Authorization for coverage of therapeutic formulas by WIC shall be for intervals of one to three months for most medical conditions, and may be renewed when prescribed by a health care provider.

WIC promotes exclusive breastfeeding. Mothers who feed both breastmilk and formula shall be encouraged and supported to return to exclusive breastfeeding, unless medically contraindicated.