



**SOUTH CAROLINA WIC PROGRAM**

**MEDICAL DOCUMENTATION FOR WIC SPECIAL FORMULA AND WIC FOODS**

- Anthropometrics required for weight related medical diagnoses. All other sections must be completed.
- Prescription is subject to WIC approval and provision based on program policy and procedure.
- Health Departments may order approved Special Formulas (not contract formulas) and it may take up to 7+ days for delivery. Approved formula list found at [www.scdhec.gov/wic](http://www.scdhec.gov/wic)

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Parent/Caretaker: \_\_\_\_\_

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

- |   |   |   |  |
|---|---|---|--|
| <input type="checkbox"/> Failure to Thrive      | <input type="checkbox"/> Cerebral Palsy               | <input type="checkbox"/> GERD                         | <input type="checkbox"/> Down's Syndrome             |
| <input type="checkbox"/> Cystic Fibrosis        | <input type="checkbox"/> Feeding tube (specify)       | <input type="checkbox"/> Malabsorption (specify)      | <input type="checkbox"/> Developmental Delay         |
| <input type="checkbox"/> Food allergy (specify) | <input type="checkbox"/> Cow's Milk Protein Allergy   | <input type="checkbox"/> Metabolic Disorder (specify) | <input type="checkbox"/> Heart/circulatory (specify) |
| <input type="checkbox"/> Other (specify)        | <input type="checkbox"/> Prematurity/Low Birth Weight |   |  |

Note: For Enfamil AR to be considered for approval, two (2) medical conditions must be documented. One condition must be GERD and the other must be one following conditions. Document in the above provided space.

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

**Current Anthropometric Data:**

Weight \_\_\_\_\_ lb \_\_\_\_\_ oz      Head Circumference \_\_\_\_\_ inch      Date Taken: \_\_\_\_\_  
 Height \_\_\_\_\_ inch      Hgb/Hct \_\_\_\_\_

**Prescribed Special Formula:**

Amount:

- \_\_\_\_\_ Ounces/day
- \_\_\_\_\_ Cans or packets/ day
- \_\_\_\_\_ Maximum issuance

Form:

- \_\_\_\_\_ Powder
- \_\_\_\_\_ Concentrate
- \_\_\_\_\_ Ready to feed

Length of Use:

- \_\_\_\_\_ 3 months
- \_\_\_\_\_ 6 months
- \_\_\_\_\_ Other

Special Instructions: \_\_\_\_\_ None

If special instructions, who has been instructed?

\_\_\_\_\_ N/A

**Supplemental Foods- Must select issue standard food package OR issue modified food package (and indicate specifics)**

\_\_\_\_\_ Issue standard food package      OR      \_\_\_\_\_ Issue MODIFIED food package (must indicate specifics below)

Infants:

- \_\_\_\_\_ No infant cereal
- \_\_\_\_\_ No infant fruit/vegetable
- \_\_\_\_\_ WIC RD to select appropriate supplemental foods
- \_\_\_\_\_ Other (specify): \_\_\_\_\_

Children and 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
- \_\_\_\_\_ WIC RD to select appropriate supplemental foods
- \_\_\_\_\_ Provide infant foods instead of fresh or frozen fruits/vegetables
- \_\_\_\_\_ Other (specify): \_\_\_\_\_

Healthcare Professional Signature \_\_\_\_\_ Date \_\_\_\_\_

WIC RD/CPA Approval Signature \_\_\_\_\_ Date \_\_\_\_\_

Healthcare Professional Printed Name \_\_\_\_\_

Office Name \_\_\_\_\_

Street \_\_\_\_\_ City, State, Zip Code \_\_\_\_\_

Phone Number \_\_\_\_\_ Fax Number \_\_\_\_\_

**"WIC USE ONLY"**

MCI # \_\_\_\_\_

Name \_\_\_\_\_

DOB \_\_\_\_\_

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

**PURPOSE:** To use when issuing a prescription for WIC approved special formula and WIC approved 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.  
**Parent/Caregiver's First and Last Name(s):** Enter the parent or caregiver's first and last name(s).  
**Medical Diagnosis:** Place a check (✓) beside one or more of the described medical condition(s) or check (✓) "other" and enter medical diagnosis. When indicated as "specify," 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 for issuance of a special formula. WIC will not provide formula to enhance nutrient intake or manage body weight without an underlying medical condition.  
**Added Rice Starch Infant Formulas:** 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.  
**Prescribed Formula:** Enter prescribed WIC special formula.  
**Amount:** Check "maximum issuance" or enter prescribed amount per day.  
**Form:** Place a check (✓) beside preferred physical form.  
**Length-of-use:** Place a check (✓) beside the time period for which the prescription is valid. Prescription not to exceed 6 months. Exception: Metabolic formula prescriptions not to exceed 1 year.  
**Special instructions/comments:** Enter any special instructions or comments, Or, check "N/A".  
**If special instruction, who has been instructed?** Enter first and last name of person taught special instructions.  
**Supplemental foods:** Select option issue modified food package (indicate specifics below) OR issue standard food package.  
**Infants:** Select options for a modified food package.  
**Children and Women:** Select options for a modified food package.  
**Healthcare Professional Signature:** Enter signature.  
**Date:** Enter date the prescription is being issued.  
**Healthcare Professional Printed Name:** Enter printed name of healthcare professional. May stamp contact information.  
**Office Name:** Enter office name.  
**Street, City, State, and Zip Code:** Enter address of medical office or clinic.  
**Phone Number/Fax Number:** Enter the office phone and fax number.  
**WIC RD/CPA Approval Signature:** Enter signature for WIC RD or CPA.  
**Date:** Enter date the prescription is approved by WIC RD or CPA.

| Children   | Pregnant or Partially Breastfeeding Women  | Fully Breastfeeding Women  | 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<br>1 lb cheese may be substituted for 3 qts<br>1 quart yogurt may be substituted for 1 quart of milk. | 22 quarts milk<br>1 lb cheese may be substituted for 3 qts<br>1 quart yogurt may be substituted for 1 quart of milk. | 24 quarts milk<br>1 lb of cheese<br>1 quart yogurt may be substituted for 1 quart of milk. | 16 quarts milk<br>1 lb cheese may be substituted for 3 qts<br>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  |
| \$8.00 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<br>24 oz infant cereals<br>9-11 months old- Optional FRESH ONLY<br>\$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<br>24 oz infant cereals<br>31- 2.5 oz infant meat<br>9-11 months old-Optional FRESH ONLY<br>\$8 Cash Value Voucher with 32- 4 oz infant fruits & vegetable |

\*Formula quantities provided are less if the infant is breastfeeding

**Office Mechanics and Filing:** This form should be filed in the participant's WIC record, with like forms together in chronological order, most recent on top.  
DHEC 2074 (08/2015)