www.manitoba.ca/fs/dhsu

THERAPEUTIC DIET AND NUTRITIONAL SUPPLEMENT REQUEST AND JUSTIFICATION

This request is in support of an individual enrolled in the following program(s):

☐ Employment and Income Assistance ☐ Manitoba Supports for Persons with Disabilities

☐ Children's disABILITY Services ☐ Community Living disABILITY Services

CLEAR FORM

This form may be completed by Registered Dietitians, Physicians, Nurse Practitioners, Physician Assistants, Nurses or Practical Nurses.

Client Surname:	Given Name:	Case Number:	Telephone / Contact Number:
Address:		Postal Code:	PHIN Number:
Date of Birth (dd/mm/yyyy):		Height: cm	Gender: ◯ M ◯ F
Current Weight: Kg		Previous Documented Weight: Kg Date of Measure (dd/mm/yyyy):	

SECTION 1 - Standard Therapeutic Diets (Adults Only)

- Please select **all** medical diagnoses which apply.
- If multiple diagnoses are selected, the diet with the highest associated dollar amount will be provided if appropriate.
- Please complete Section 2 if prescribing a **non-standard therapeutic or pediatric diet** not listed below.
- Please complete Section 3 if dietary need is best met through **nutritional supplements**.

Chronic Condition Review in: month(s)

Increased nutritional needs associated with the following condition(s):

☐ ALS ☐ Lupus
☐ Cirrhosis (stage 3 & 4) ☐ Malignancy
☐ Crohn's Disease ☐ Multiple Sclerosis
☐ Chronic Wounds/Burn ☐ Ostomy
☐ Cystic Fibrosis ☐ Pancreatic Insufficiency
☐ HIV ☐ Ulcerative Colitis
☐ Hepatitis C

Note: for the conditions listed below, please complete Section 2 including date of diagnosis, stage (where appropriate) and treatment plan.

☐ Malignancy ☐ Chronic Wounds/Burns

High Protein/Calorie Review in: month(s)

Along with the diagnosis of one of the **chronic conditions** listed above or a diagnosis outlined in Section 2, the individual requires a high protein/ calorie diet based on the following:

- **Is showing evidence of unintentional weight loss/ body wasting; or**

Y ◯ N ◯ *Height and Weight are required as requested above*

- **Requires 100 grams or more protein per day; or**

Y ◯ N ◯ *Justification needs to be provided in Section 2*

Has increased energy needs.

Y ◯ N ◯ *Note: If higher calorie amount required, please complete Section 2 providing rationale using Harris-Benedict Equations revised by Mifflin and St. Jeor - 1990.*

Diabetic Review in: month(s)

** Diagnosis confirmed by Fasting Plasma Glucose Test*

☐ Adult (Women = 1800 cal; Men = 2000 cal.)

Note: If higher calorie amount required, please complete Section 2 providing rationale using Harris-Benedict Equations revised by Mifflin and St. Jeor - 1990.

☐ Gestational Diabetes Due Date:

Renal Review in: month(s)

☐ Pre-dialysis (GFR<30)

☐ Hemodialysis / Peritoneal Dialysis

Gluten Free Review in: month(s)

☐ Celiac Disease Y ◯ N ◯

Confirmed via biopsy or antibody testing

☐ Wheat Allergy *(tests completed)* Y ◯ N ◯

Controlled Sodium Review in: month(s)

☐ Hypertension
☐ Heart Failure
☐ COPD

Controlled Fat or Modified Fat plus Controlled Sodium

Review in: 9 month(s)

☐ Elevated Serum Lipids
☐ Short Bowel Syndrome
☐ Fatty Liver

SECTION 2 - Non Standard Therapeutic and Pediatric Diet

To be completed for diets not reflected in Section 1 including Bland and Controlled/Low Protein

Diagnosis / Rationale :

Medically appropriate diet for this condition :

Review in : month(s)

SECTION 3 - Nutrition Supplements and Products (Children and Adults)

If nutritional supplements are combined with a therapeutic diet request, rationale must be provided below.
If the energy (calories) from prescribed nutrition supplements equals or exceeds 50% of daily requirement, the therapeutic diet allowance may be adjusted accordingly.

Diagnosis / Rationale :

Supplement/ product Required:

Amount: units per day Flavor(s) if available:

Is the Manitoba Home Nutrition Program Involved: Y N

Review in : month(s) Delivery Address *(if different from page 1)*

Not to exceed 12 months

Signature of Regulated Health Professional:

Title: Date of Request:

Name: Phone Number: Fax:

Family Services is authorized to collect personal information and personal health information under section 36(1)(b) of ***The Freedom of Information and Protection of Privacy Act*** ("FIPPA") and section 13(1) of ***The Personal Health Information Act*** ("PHIA") respectively, as the information is directly related to and necessary for the purposes of administering eligible supports provided by the programs identified at the top of this document and facilitating the procurement and delivery of medical supplies and equipment. We have limited the information we are collecting about you to the minimum amount necessary for these purposes. Your information is protected by the protection of privacy provisions of FIPPA and PHIA. We cannot use or disclose it for any other purpose, unless you consent or we are authorized or required to do so by FIPPA and PHIA. If you have any questions about your information, please contact the FIPPA Coordinator at (204) 945-2013 or 2nd floor 114 Garry Street, Winnipeg MB R3C 4V4.

PLEASE FORWARD COMPLETED REQUEST ELECTRONICALLY, E-MAIL , FAX OR MAIL TO:
Disability and Health Supports Unit - Provincial Services / 100 - 114 Garry Street, Winnipeg MB R3C 1G1
TELEPHONE INQUIRIES, PLEASE PHONE (204) 945-4393 or toll free: 1-877-587-6224; or FAX (204) 945-1436 or E-MAIL disandhealthsupports@gov.mb.ca

This information available in alternate formats upon request
Ces renseignements sont offerts dans de multiples formats sur demande.