

# THERAPEUTIC DIET AND NUTRITIONAL SUPPLEMENT REQUEST AND JUSTIFICATION

[www.manitoba.ca/fs/dhsu](http://www.manitoba.ca/fs/dhsu)

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

- Employment and Income Assistance     
  Children's disABILITY Services     
  Community Living disABILITY

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

Client Surname:	Given Name:	EIA Case Number:	Telephone / Contact Number:
<input style="width: 90%;" type="text"/>	<input style="width: 90%;" type="text"/>	<input style="width: 90%;" type="text"/>	<input style="width: 90%;" type="text"/>
Address:		Postal Code:	PHIN Number:
<input style="width: 95%;" type="text"/>		<input style="width: 80%;" type="text"/>	<input style="width: 90%;" type="text"/>
Date of Birth(yyyy-mm-dd):	Height:	cm	Gender: <input type="radio"/> M <input type="radio"/> F
Current Weight:	Kg	Previous Documented Weight:	Kg
		Date of Measure (yyyy-mm-dd):	

## 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.
- If prescribing a **non-standard therapeutic or pediatric diet** not listed below, please complete Section 2.
- If dietary need is best met through **nutritional supplements**, please complete Section 3.

<p><b>Chronic Condition</b>      Review in:      month(s)</p> <p>Increased nutritional needs associated with the following condition(s):</p> <table style="width: 100%; border: none;"> <tr> <td><input type="checkbox"/> ALS</td> <td><input type="checkbox"/> Lupus</td> </tr> <tr> <td><input type="checkbox"/> Cirrhosis (stage 3 &amp; 4 )</td> <td><input type="checkbox"/> Malignancy</td> </tr> <tr> <td><input type="checkbox"/> Crohn's Disease</td> <td><input type="checkbox"/> Multiple Sclerosis</td> </tr> <tr> <td><input type="checkbox"/> Chronic Wounds/Burn</td> <td><input type="checkbox"/> Ostomy</td> </tr> <tr> <td><input type="checkbox"/> Cystic Fibrosis</td> <td><input type="checkbox"/> Pancreatic Insufficiency</td> </tr> <tr> <td><input type="checkbox"/> HIV</td> <td><input type="checkbox"/> Ulcerative Colitis</td> </tr> <tr> <td><input type="checkbox"/> Hepatitis C</td> <td></td> </tr> </table>	<input type="checkbox"/> ALS	<input type="checkbox"/> Lupus	<input type="checkbox"/> Cirrhosis (stage 3 & 4 )	<input type="checkbox"/> Malignancy	<input type="checkbox"/> Crohn's Disease	<input type="checkbox"/> Multiple Sclerosis	<input type="checkbox"/> Chronic Wounds/Burn	<input type="checkbox"/> Ostomy	<input type="checkbox"/> Cystic Fibrosis	<input type="checkbox"/> Pancreatic Insufficiency	<input type="checkbox"/> HIV	<input type="checkbox"/> Ulcerative Colitis	<input type="checkbox"/> Hepatitis C		<p><b>Diabetic</b>      Review in:      month(s)</p> <p><input type="checkbox"/> Adult (Women = 1800 cal; Men = 2000 cal.)</p> <p><i>If higher calorie amount required, please complete Section 2 providing rationale (e.g. Mifflin St. Jeor or Harris-Benedict Equations)</i></p> <p><input type="checkbox"/> Gestational Diabetes (2200 calories)</p> <hr/> <p><b>Renal</b>      Review in:      month(s)</p> <p><input type="checkbox"/> Pre-dialysis (GFR&lt;30)</p> <p><input type="checkbox"/> Hemodialysis / Peritoneal Dialysis</p>
<input type="checkbox"/> ALS	<input type="checkbox"/> Lupus														
<input type="checkbox"/> Cirrhosis (stage 3 & 4 )	<input type="checkbox"/> Malignancy														
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<input type="checkbox"/> HIV	<input type="checkbox"/> Ulcerative Colitis														
<input type="checkbox"/> Hepatitis C															
<p><b>High Protein/Calorie</b>      Review in:      month(s)</p> <p>Along with the diagnosis of one of the <b>chronic conditions</b> listed above or a diagnosis outlined in Section 2, the individual requires a high protein/ calorie diet based on the following:</p> <ul style="list-style-type: none"> <li>• <b>Is showing evidence of unintentional weight loss/ body wasting; or</b></li> </ul> <p>Y <input type="radio"/>      N <input type="radio"/>      <i>Height and Weight are required as requested above</i></p> <ul style="list-style-type: none"> <li>• <b>Requires 100 grams or more protein per day; or</b></li> </ul> <p>Y <input type="radio"/>      N <input type="radio"/>      <i>Justification needs to be provided in Section 2</i></p> <ul style="list-style-type: none"> <li>• <b>Has increased energy needs.</b></li> </ul> <p>Y <input type="radio"/>      N <input type="radio"/>      <i>Justification needs to be provided in Section 2 providing rationale (e.g. Mifflin St. Jeor or Harris-Benedict Equations)</i></p> <p><small>* If no justification is outlined as requested above, a <b>Chronic Condition</b> diet will be provided.</small></p>	<p><b>Gluten Free</b>      Review in:      month(s)</p> <p><input type="checkbox"/> Celiac Disease      Y <input type="radio"/>      N <input type="radio"/></p> <p><i>Confirmed via biopsy or antibody testing</i></p> <p><input type="checkbox"/> Wheat Allergy (<i>tests completed</i>)      Y <input type="radio"/>      N <input type="radio"/></p> <hr/> <p><b>Controlled Sodium</b>      Review in:      month(s)</p> <p><input type="checkbox"/> Hypertension</p> <p><input type="checkbox"/> Heart Failure</p> <p><input type="checkbox"/> COPD</p> <hr/> <p><b>Controlled Fat or Modified Fat plus Controlled Sodium</b></p> <p style="text-align: right;">Review in:      month(s)</p> <p><input type="checkbox"/> Elevated Serum Lipids</p> <p><input type="checkbox"/> Short Bowel Syndrome</p> <p><input type="checkbox"/> Fatty Liver</p>														

## SECTION 2 - Non Standard Therapeutic and Pediatric Diet

To be completed for diets not reflected in Section 1 included Bland and Controlled/Low Protein diet requests.

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 945-2013 at 500-326 Broadway, Winnipeg MB R3C 0S5.

PLEASE FORWARD COMPLETED REQUEST ELECTRONICALLY, E-MAIL , FAX OR MAIL TO:

Disability and Health Supports Unit - Provincial Services / 102 - 114 Garry Street, Winnipeg MB R3C 1G1

TELEPHONE INQUIRIES, PLEASE PHONE (204) 945-2197 or toll free: 1-877-587-6224; or FAX (204) 945-1436 or E-MAIL [disandhealthsupports@gov.mb.ca](mailto:disandhealthsupports@gov.mb.ca)

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