First Nation Income Assistance Program
Medical Release and Assessment for Therapeutic Diet Benefits
Personal and Confidential

I, _____ of _____
(Person or Guardian) (Address)
authorize the release of medical information to _____
(Administering Authority)
in order to determine eligibility for therapeutic diet requirements, food supplements, or other medical benefits.

_____ _____
(Signature of Person Issuing Release) (Date)

_____ _____
(Signature of Income Assistance Administrator) (Date)

TO BE COMPLETED BY EXAMINING HEALTH PROFESSIONAL:

Information Required to Determine Medical Eligibility:

Name of Patient: _____ Treaty Number: _____

Medical Condition:
_____

Therapeutic Diets (Please check all that apply):
_____ Diabetic Diet Kcal Required (choose between 1000Kcal and 3000Kcal) _____
_____ Kidney Dialysis
_____ Controlled Sodium or Low Cholesterol
_____ Low Fat
_____ High Protein
_____ Controlled or Low Protein
_____ Gluten Free
_____ Bland Diet (Gastric Diet, Ulcer Diet, Pureed Food)
_____ Low Sodium (less than 5 grams)

Other Medical Requirements:
_____

_____

Name and Address of Health Professional:
(Please print)
_____
_____
_____

_____ _____
(Signature of Health Professional) (Date)

_____
(Title of Health Professional)

For Income Assistance Administrator Use Only:

Expiry Date of Medical Form: _____