

**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: \_\_\_\_\_