Saskatchewan Ministry of Social Services

Medical Report

Case Number: 2581999

This report is an important document, but is not the only eligibility factor. The information assists in determining how the client's physical or mental condition affects the client's ability to work or to verify the need for a special diet.

This section to be completed by Worker: **Date issued:** 2014 / 10 / 01 (Year Month Day)

Client's Surname: Tremblay First Name: Tim

Address: 403 - 510 Ladner St W City, Town: Moose Jaw

Birthdate ____/____/____ (Year Month Day)

Worker's Name and Phone Number: Carla Knull (306) 694-3415

Worker's comments/questions _____

The client indicated above requires medical information for social assistance purposes as indicated:

- ☐ **To identify a short term illness or a disability lasting longer than 12 months which affects training or employment capacity.**
- ☑ **To verify the need for a special diet. (questions 8, 9 or 10 on reverse)**

Thank you for taking the time to complete this form. It is very helpful in assessing the client's employability or need for a special diet.

Any additional examinations are the financial responsibility of the client unless requested and authorized by Social Services.

Return by ____/____/____, **to:** (Year Month Day)

MINISTRY OF SOCIAL SERVICES
36 Athabasca Street West
MOOSE JAW SK S6H 6V2

Authorization

I hereby authorize any health care professional who has observed or attended me, to give full information regarding my condition including history, consultation reports, and diagnosis, to Social Services for the purpose of determining my eligibility for social assistance benefits.

November 8 2014 (Date)

Timothy James Tremblay (Signature of client/trustee)

Diagnosis and history – Height: 5'10" Weight: 180 lbs

How long has patient been under your care? 3 years

1. Does the patient have a **short term** illness or condition (under 12 months)? Yes ☑ No ☐
   Diagnosis _____

OR

2. Does the patient have a **prolonged** physical or mental condition (over 12 months)? Yes ☐ No ☐
   Diagnosis _____
   If yes to either above question, please explain below.

3. Does the condition limit employment/training capacity? Yes ☐ No ☐
   Treatment: _____
   Prognosis: _____

4. Present medication: _____
   If any of the above medications affect the patient's activities, please explain:

5. If the patient is not able to work at this time, when can he/she be expected to be ready for work? (approximate number of days, weeks, or months) _____. Can the patient return to former occupation? Yes ☐ No ☐

If Yes, are there any restrictions? (please describe) _____

If No, please indicate reason _____

6. Is patient capable of any other work? Yes ☐ No ☐

If Yes, what type of work? _____

If No, why is the patient not capable of work? _____

7. Does patient have an addiction problem? Yes ☐ No ☐

Do you believe the patient would benefit from addiction treatment? Yes ☐ No ☐

If Yes, please indicate where you will be referring him/her _____

Special Diet – To be completed by Physician or Nurse Practitioner only.

8. If patient is pregnant, expected birth date: _____

9. Does the patient's child require infant formula? Yes ☐ No ☐
If Yes, name of formula: _____ Number of months required: _____

10. The following list includes commonly prescribed special diets where expenses exceed normal food costs.

The need for a diet is reviewed every 12 months.

Reason special diet is required: hyperlipidemia

If a diet is required, please check **one**:

☐ High Protein for **acute conditions where the treatment is intensive** and for a specific time period.

Number of months required: _____

☒ Caloric Level – **(Please circle reason)** diabetes, weight reduction, modified fats

Daily calories: ☐ **1900 – 2499** ☒ **2500 – 2999** ☐ **3000 +** **Length of time required** 1 yr.

☐ Food Supplements (Boost, Ensure, etc.) – **for specific condition and time period.**

Name of supplement: _____

Number of cans/day: _____ Length of time required: _____

☐ Dialysis

☐ HIV/AIDS

☐ Other (describe) _____

I B. JANDERSON am a Physician licensed to practice in Saskatchewan.
(Print – Health professional's name) (professional discipline)

Address: Suite 401, 510 MAIN ST N MOOSE JAW SASK

This report contains my clinical assessment and considered opinion at this time.

Date completed: 8/11/14 Signature: B. Janderson

Payment for completion of this form is covered through the Medical Services Plan. See Section A (General Services).

Fax Cover Page
Number of pages including cover, 3 pages.

November 10, 2014

Fax: 306 694 3418

To: Ministry of Social Services
36 Athabasca Street West
Moose Jaw SK , CA
S6H 6V2
Attention: Carla Knull, Assured Income Specialist

Re: Timothy James Tremblay Ref # 2581999
403- 510 Laurier Street West
Moose Jaw SK , S6H 6X6

Please find enclosed Medical Report dated November 08, 2014.

Sincerely,

Timothy James Tremblay

Timothy James Tremblay