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:** 2013/10/23
Year Month Day

Client's Surname: Tremblay First Name: Timothy

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

Birthdate ____/____/____
Year Month Day

Worker's Name and Phone Number: Carla Knull (fax 306-694-3418)

Worker's comments/questions Special diet funding expires Dec 31, 2013
Please address further

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)**

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

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

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.

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.

Friday November 29, 2013 (Date) — [signature] (Signature of client/trustee)

Diagnosis and history – Height 5'10" Weight: 178 lbs

How long has patient been under your care? ____________

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: hyperlipidaemia

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

Address: Suite 407, 310 MAIN St. N MOOSE JAW SASK

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

Date completed: 29/11/13 Signature: [signature]

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