

**Fax Cover**

**Number of pages including cover page, 4 pages.**

**FAX: (306) 694 3418**

**Attention: Mr. Larry Pfeifer, Supervisor Income  
Assistance & Disability Services  
Ministry of Social Services Saskatchewan  
36 Athabasca Street West  
Moose Jaw SK Canada  
S6H 6V2**

**RE: Tim Tremblay Case # 2581999. Application for medical  
form for special diet.**



Tim Tremblay  
403 -510 Laurier Street West  
Moose Jaw SK Canada  
S6H 6X6

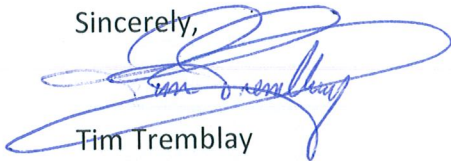
October 21, 2013

Larry Pfiefer  
Ministry of Social Services  
36 Atahbasca Street West  
Moose Jaw SK Canada  
S6H 6V2

Mr. Larry Pfiefer

Please accept this letter as my request for a medical form for my special diet.  
Enclosed is a copy of my last medical form completed by Dr. Sanderson on November 15, 2012.

Sincerely,



Tim Tremblay





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: 12/11/15  
Year Month Day

Client's Surname: Tremblay First Name: Timothy

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

Birthdate: 06/02/10 S6H 6V6  
Year Month Day

Worker's Name and Phone Number: Pat Wilson

Worker's comments/questions: Please complete question 10 regarding Mr. Tremblay requirement for a prescribed special diet.

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

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 2013 01 31 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.

January 2, 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 year

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: Roxolone 12g tid prn  
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 neck pain + r/ring low back pain → (4) leg  
on activity + prolonged sitting or standing

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? see above

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: hypothyroidism

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 year

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, 510 MAIN ST - N, MOOSE JAW

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

Date completed: 2/1/13 Signature: [Signature]



Ministry of  
Social  
Services

Income Assistance

36 Athabasca Street West  
MOOSE JAW, SK Canada  
S6H 6V2

Phone: (306) 694-3647  
Fax: (306) 694-3418

Case #2581999

Timothy Tremblay  
403 - 510 Laurier Street  
MOOSE JAW SK S6H 6X6

Dear Mr. Tremblay:

I am writing to introduce myself as your Income Assistance Worker.

You are required to report all changes in your/your spouse's circumstances. Your cooperation is requested to ensure your continued eligibility.

If you have any questions or concerns feel free to contact me.

Sincerely,

Larry Pfeifer  
Supervisor  
Income assistance & Disability Services  
306-694-3835

TRANSMISSION VERIFICATION REPORT

TIME : 10/21/2013 10:24  
NAME : CAREER EMPLOYMENT MJ  
FAX : 13066943061  
TEL : 13066943699  
SER.# : 00000010417

DATE, TIME	10/21 10:23
FAX NO./NAME	93066943418
DURATION	00:00:43
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MODE	STANDARD ECM