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

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:** 12 / 11 / 15 (Year Month Day)

Client's Surname: Tremblay First Name: Timothy

Address: 403 510 Laurier St City, Town: Moose Jaw S6H 6X6

Birthdate 66 / 02 / 10 (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. Thank You

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 2013 01 31, **to:** (Year Month Day)

MINISTRY OF SOCIAL SERVICES
36 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.

January 2, 2013 (Date) — Dave Tremblay (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: Ramipril 10mg tab pm
   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 + upper low back pain > 4 hrs 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: hypercholesterolemia

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. CANDERAN am a Physician licensed to practice in Saskatchewan.

(Print Health professional's name) (professional discipline)

Address: Suite 407, 310 MAIN ST. N., MOOSE JAW

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

Date completed: 2/1/13 Signature: B. Canderan

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

Saskatchewan

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.# : 000000010417

DATE,TIME	10/21 10:23
FAX NO./NAME	93066943418
DURATION	00:00:43
PAGE(S)	04
RESULT	OK
MODE	STANDARD ECM