Alberta Health Services

AHS Nutrition Services Request for Nutrition Funding
Family Support for Children with Disabilities

Requester Details

Name of Child *(last, first name)*	Date of Birth *(yyyy-Mon-dd)*	Date of Request *(yyyy-Mon-dd)*

Parent's/ Guardian's *(last, first name)*	Contact Number

FSCD Worker's Name *(last, first name)*	Email	Phone	Fax

Purpose of Request

☐ Initial Request ☐ Change Request ☐ Renewal Request with changes ☐ Renewal Request no changes

Disability Related Rationale for Request

By completing this form, the Registered Dietitian/Physician is acknowledging that the need for the outlined nutrition prescription is recognized as a non-experimental regimen to manage an identified condition or meet the child's nutrition needs

Oral Nutrition: ☐ Yes ☐ No

1. Food Intake: Food is providing _____% of estimated nutrition needs *(FSCD to determine cost)*\
2. Special Diet: ☐ Yes ☐ No If Yes, Please list _____

Oral Prescribed Formula ☐ Yes ☐ No

1. Formula Required
   a) Formula Type *(specify)* _____ Amount required _____ *(cases)* per year ____units/case
   b) Second Formula Type *(specify)* _____ Amount required _____ *(cases)* per year ____units/case
2. Thickener Required
   a) Thickener *(specify)* _____ Amount required _____ *(cases)* per year ____units/case
3. Module/Additives Required
   a) Module/Additives *(specify)* _____ Amount required _____ *(cases)* per year ____units/case
   b) Module/Additives *(specify)* _____ Amount required _____ *(cases)* per year ____units/case

Tube Feed Prescribed Formula (Enteral Nutrition) ☐ Yes ☐ No

1. Formula Required
   a) Formula Type *(specify)* _____ Amount required _____ *(cases)* per year ____units/case
   b) Second Formula Type *(specify)* _____ Amount required _____ *(cases)* per year ____units/case
   c) Additional Formula Type *(specify)* _____ Amount required _____ *(cases)* per year ____units/case
2. Module/Additives Required
   a) Module/Additives *(specify)* _____ Amount required _____ *(cases)* per year ____units/case
   b) Module/Additives *(specify)* _____ Amount required _____ *(cases)* per year ____units/case
   c) Module/Additives *(specify)* _____ Amount required _____ *(cases)* per year ____units/case

Formula Acquisition and Contact

Formula ordered through: ☐ Stollery Home Nutrition Support Program (HNSP) ☐ ACH Home Nutrition Support Program
☐ Pharmacy _____ ☐ Other _____

Registered Dietitian's Name	Registered Dietitian's Contact	Registered Dietitian's Signature

Fax this completed form to the child's FSCD worker

FSCD Use only *(refer to the document: Diet Costing Toolkit FSCD program)*

Food Only	Food and Formula	Formula Only
Cost of Food $_____ /month	Cost of Food $_____ /month	Cost of Formula $_____ /month
- Parental Portion $_____ /month	+ Cost of Formula $_____ /month	- Parental Portion/Co-Pay $_____ /month
FSCD Annual Commitment $_____ /year	- Parental Portion $_____ /month	FSCD Annual Commitment $_____ /year
	FSCD Annual Commitment $_____ /year	