Winnipeg Regional Health Authority / Office régional de la santé de Winnipeg
Caring for Health / *À l'écoute de notre santé*

Client Name: _____
PHIN: _____
MHSC: _____
Date of Birth: _____
Gender: _____

Or client label

MANITOBA HOME NUTRITION PROGRAM
SPECIALTY INFANT FORMULA (SIF) PROGRAM CONSULT FORM

BIRTH – 1 YEAR (CORRECTED AGE FOR PRETERM INFANTS)

Referring Physician:	Parent(s)/Guardian(s):
Phone: Fax:	Caregiver's Contact Info: Phone: _____ Address: _____ _____
Please indicate the subspecialty that will be following or to which a referral has been initiated: ☐ Allergy ☐ Cardiology ☐ Feeding Clinic ☐ Gastroenterology ☐ Metabolics ☐ Nephrology	Pediatrician:

Medical Diagnosis:		
Relevant Medical/Surgical History:		
Weight (kg): (date: Month / Day / Year)	Height (cm): (date: Month / Day / Year)	Head Circumference (cm): (date: Month / Day / Year)
Comments:		

PLEASE ATTACH A COPY OF CLIENT'S GROWTH CHART

Formula Trialed	Length of Trial	Reactions/Results

Formula Requested/Recommended?	Were other funding sources explored?
☐ Monagen ☐ Neocate Infant ☐ Neocate Junior ☐ Nutramigen A+ ☐ Pregestimil A+ ☐ Neocate ☐ Ross Carbohydrate Free ☐ Similac PM 60/40	☐ Employment & Income Assistance ☐ Child & Family Services ☐ Not Applicable
Is the formula required for more than 3 months? ☐ Yes ☐ No	

Signature/Designation_____ Date _____

SIF Program: Fax: (204) 474-2387 Phone: (204) 235-8861