User Identification

List of important points when making a request

Below is a list of important points to remember when making a request to the MSSS Enteral Nutrition Program. Any omission or missing information will result in a delay in handling the request.

Check off and return this list with documents supporting your request

	YES	NO
All parts of the questionnaire have been completed.		
The patient or respondent is aware of how the program works and what enrolment in the program involves and the form has been signed by the patient or respondent.		
The physician's signature attesting to the fact that the patient's condition is irreversible and/or permanent and/or long-term is attached to the request.		
Justification for requesting a closed system is included, if applicable		
The institution that will follow up with the program has been notified of this request. If not, this should be done.		
The patient has private insurance.		
The acceptance or refusal letter from the private insurer (if applicable) is attached to the request.		
The patient lives in a private residence that is not subsidized by the government.		
A request has been made to **all** agencies that could provide the patient with some form of assistance in relation to this request where applicable (social welfare, public curator's office, Veterans Affairs, CSST, SAAQ, IVAC, Canadian Cancer Society, Indian Affairs or any other agency with which the patient may be associated.)		
The patient already receives partial or total assistance from another agency. (If applicable, explain how this aid is provided.)		
The duration of tube feeding (gavages) is known or determined.		
❒ short term (less than 2 years) ❒ long term (more than 2 years)		

3175, Côte Sainte-Catherine
Montréal (Québec) H3T 1C5

PROGRAMME MINISTÉRIEL D'ALIMENTATION ENTÉRALE À DOMICILE DU QUÉBEC

Trust :
CHU SAINTE-JUSTINE
SERVICE LIAISON/CONSULTATION RÉSEAU

User identification

Every section must be duly completed.
Any omission will result in a delay in handling the request.

***** Print the hospital card or write the user's information below.

1. User identification

Last name_____ **First name**_____

Date of birth: _____/_____/_____ **Gender F** □ **M** □
year month day

Health insurance number __ __ __ __ / __ __ __ __ / __ __ __ __

Permanent address:

_____
no street apt city/town postal code

Tel.: (___) _____ **Emergency no. : (___)**_____

Cell number: (___) _____ **Email Address:** _____

Language of communication: French □ **English** □ **other** □

Name of user's representative (if applicable) _____

Relationship to user: Father/mother □ **Guardian** □ **Other (specify)** _____

2. Identification of referring institution

Name of institution: _____

Form completed by: _____**position:**_____

Telephone number: _____ **Extension:** _____

Fax number: _____

3. Identification of healthcare worker and/or institution that will follow up with the program

Healthcare worker: _____ **position :**_____

Name of institution: _____

Telephone number: _____**Extension:**_____

Email address: _____

4. Eligibility

Treating physician _____

Place of practice: _____

Tel.: (___) _____Extension:_____ Fax: (____) _____

Signature of physician attesting to this request: _____

Patient already at home YES □ NO □

If no, anticipated date of discharge: _____/_____/_____
year month day

User's primary diagnosis*:_____

***The physician's signature guarantees the diagnosis. The diagnosis must relate to the current request and involve an inability to obtain nutrition by swallowing.**

Note that the patient must live in a private residence. Any patient residing in an institution that is subsidized by the MSSS is ineligible.

Can the required equipment and supplies be funded in whole or in part by another agency?

SAAD □ Income security □ CSST □ IVAC □

RAMQ □ SAAQ □ Other_____

Private insurance: _____**

****Attach the acceptance or refusal letter from the private insurer to this request**

Explain what level and what means of assistance is provided:

_____

_____

_____

_____

5. **Patient Agreement (completed by the patient or respondent)**

Agreement to collaborate in the implementation of the service plan

I, the undersigned, _____, residing at _____

declare that, to the best of my knowledge, the information provided is complete and truthful. I agree to notify CHU Sainte-Justine without delay of any change in my situation or the situation of _____ that would render the information that I have provided for consideration of my (his/her) request inaccurate.

I agree to collaborate in the implementation of my (his/her) service plan.

In the event that CHU Sainte-Justine accepts to provide material assistance to ensure the implementation of the service plan, I agree to use this material assistance strictly for the purposes described in the letter of acceptance, which lists every item for which the material assistance is granted. In addition, I agree to notify CHU Sainte-Justine if the devices or equipment for which the material assistance is granted are no longer being used, so that this agency can assign them to other individuals.

I hereby authorize CHU Ste-Justine to request or release information that is deemed necessary to evaluate and handle my service plan (the service plan of _____) to competent individuals or agencies involved.

In witness whereof, I have signed at _____ on _____
City or town

_____	**_____**
Signature of the person making the request	**Signature of representative (if applicable)**
Note that the person must sign if 14 years of age or older.	**NB: Such representation is only possible if Whom the request is being made is under 18 years of age or over 18 years of age but incapable of managing his/her affairs.**

Identification of the person agreeing to collaborate in the implementation of the service plan

□ Person himself/herself **□ Father-mother** **□ Guardian** **□ Host family**

□ Spouse **□ Curator** **□ Other (specify) _____**

Identification of supplies			Anticipated frequency of use
☐ **Pomp : _____**	**Teaching : ☐YES ☐NO**		
☐ **Feeding tubes #_____ (Closed system)**	☐ **Feeding bags #_____ (Open system)**		
☐ **Gravity bags #8884702500**	☐ **Gravity bags #702505**		
☐ **Catheter plugs serynges (2oz)**	☐ **Luer-lock tip serynges (60cc)**	☐ **ENFIT serynges (60ml)**	

6. Nutrition

Solution: _____
Administration route: ☐ **GASTROSTOMY** ☐**TNG** ☐ **TNJ** ☐ **JÉJUNOSTOMY** ☐**OTHER : _____**
Daily quantity of solution administered: _____

Other requests:

_____

_____

_____

_____

Signature of the professional who completed the request form:

_____

Date: _____

Send us this form by email at "programme.ministeriel.hsj@ssss.gouv.qc.ca" or mail it to CHU Sainte-Justine, Service Liaison/Consultation Réseau or fax to:

Programme Ministériel d'alimentation entérale
3175 Côte Sainte-Catherine
Étage 7, Bloc 6
Montréal, QC. H3T 1C5 Tel.: 514-345-4931 ext. 5725 / Fax : 514-345-4983