The Teresa Group
Hearing the Voices of Children

INFANT FORMULA APPLICATION FOR MOTHERS LIVING WITH HIV

Date of Request ______________________________

Request from: ___ AGENCY ___CLINIC ___ PHYSICIAN'S OFFICE ___HOSPITAL __OTHER

Name of Requesting Professional ____

Address ____

Phone Number _________________________ Fax Number __________________________

Mom's Full Name

____

Mom's Date of Birth _____________________________________

Mom's Phone Number _____________________ Can a message be left at this number? ___ Yes ___No

Alternate Contact Number or Email ____

Mom's HIV Status Verified by (Name and Position) ____

Year of HIV Diagnosis: _______________________________

Place/Country of Birth: ___________________________________

Ethnicity: ____

Date of arrival (if applicable) _______________________________

Current town/city residence ________________________________

First Language (*please indicate if client requires an interpreter*) _______________________________________

Baby's First Name (if known) ___________________________ Sex (if known/want to indicate): __________

Due Date ___________________________________

355 Church Street Toronto, ON, M5B 0B2
T: 416-596-7703 Ext 314
F: 416-596-7910
C:647-482-7703
www.teresagroup.ca
Charitable Business Number: 133699959RR0001

Formula Requested

Brand Name ((Enfamil, Similac or Nestle): ___________________________________

___ Liquid Concentrate ___Ready-to-Feed _____Powder* (Requires additional consent form)

Please Note:
Liquid concentrate formula will be provided unless the doctor specifies otherwise. If ready-to-feed formula is required, please indicate the reason. If powder is requested, a physician must sign an additional form (available upon request) approving the use of powder formula where liquid formats are available.

Payment Options

i) _____ The Teresa Group will order directly from pharmacy or;

ii) _____ The Agency/Hospital will bill The Teresa Group (*Only for Authorized Agencies/Hospitals*)

Please Circle:

DISCLOSED TO PHARMACY **DO NOT DISCLOSE TO PHARMACY**

Pharmacy name and address/Main Intersections: ____

Pharmacy Contact Name: ______________________

Pharmacy Phone Number: ______________________ Pharmacy Fax Number: _______________________

Note: The Teresa Group staff will provide any additional information to mothers once application has been processed.

Additional Information
In order to have the information necessary to assess the best process for future assistance, please complete the following questions:

Family Source of Income: ___ODSP ___ Ontario Works ___C.P.P ___Employed

Family Status: _____ Single Parent Family ______ Two-Parent Family
Number of Children in household _______

Please return the completed application to The Teresa Group by emailing gmceyeson@teresagroup.ca or by fax to The Teresa Group - (416) 416.596.7910