

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 _____

email address _____

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, 2nd Floor, Toronto, ON, M5B 0B2

T: 416-596-7703

F: 416-596-7910

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 sfuentes@teresagroup.ca or by fax to The Teresa Group : 416-596-7910