The Teresa Group
Hearing the Voices of Children

Infant Formula Program
This program is funded by the Ontario Ministry of Health and Long-Term Care.

HEALTH PROVIDER INFANT FORMULA REFERRAL FORM

Date of Request _____

REQUEST MADE FROM

Name of: Physician/HIV Specialist ☐ Registered Nurse/Nurse Practitioner ☐ Registered Social Worker ☐

Please note that we can only accept referrals from clinicians above to the Infant Formula Program

Name of Referee _____

Address _____

Phone Number _____ Fax Number _____

email address _____

QUESTIONS TO CLINICIAN:

Have you discussed the options available for infant feeding with your patient/client? ☐ Yes ☐ No

If you have answered no to this question, we ask that you please advise your patient about their options to breastfeed or to formula feed prior to your referral.

Please note: The role of the infant formula program staff is to provide formula to clients and provide resources on infant feeding. we are unable to provide advice on options for infant feeding.

Who will be providing on-going infant feeding support/guidance/information to this patient?

_____

_____

355 Church Street, 2nd Floor, Toronto, ON, M5B 0B2
T: 416-596-7703
F: 416-596-7910
www.teresagroup.ca
Charitable Business Number: 133699959RR0001

CLIENT INFORMATION:

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 _____

Relationship of Alternate Contact _____

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 _____

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.

Formula Access 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*)

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 about the Infant formula program to mothers once application has been processed.

Please return the completed application to The Teresa Group by emailing sfuentes@teresagroup.ca **or by fax to The Teresa Group: 416-596-7910**