

EXCEPTIONAL REQUEST FORM: NUTRITIONAL PRODUCTS

**PROTECTED B
WHEN COMPLETED**

SECTION 1: PRESCRIBER/PATIENT INFORMATION

Prescriber name:		Prescriber #:
Prescriber address:		
Prescriber phone:	Fax:	Date (dd/mm/yyyy):
Patient's surname:		Given name(s):
Date of birth (dd/mm/yyyy):		Gender:
PHN:		Status #:
Pharmacy name:	Fax:	Pharmacy phone:
Product requested:		DIN:

SECTION 2: TO BE COMPLETED BY PRESCRIBER

If approved, coverage is provided for an initial period of up to six months, with reassessment required for continued coverage.

Patient's medical condition/diagnosis: _____

*If indication is palliative, please indicate if Client meets the First Nations Health Authority (FNHA) Health Benefits definition for palliative care below.

Dosage and Frequency: _____ Expected duration of therapy: _____

PLEASE INDICATE THE FOLLOWING:

- Percentage (%) of daily food intake that this nutrition product represents or will represent: _____%
- Please specify route of administration: Oral Enteral tube feeding
- Rationale for the use of this nutrition product vs regular food intake:

Please provide documentation if available.

Use in palliative care:

- The patient has been diagnosed with a terminal illness or disease which is expected to be the primary cause of death within six (6) months or less.

Comments/specialist name (if applicable):

Prescriber signature: _____

Date: _____

**Fax toll-free: 1-888-299-9222 or mail to:
Health Benefits
First Nations Health Authority
540 - 757 West Hastings Street,
Vancouver, BC V6C 1A1**



First Nations Health Authority
Health through wellness

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