

Local ODSP Office Stamp

OHIP Fee Code
K055 (\$20.00)

**When this form has been completed,
please return it to your local office.**

Information for ODSP Recipient to Complete

Last name of the person who has a special diet requirement

First name

Initial

Date of birth

day mo. year

Member ID

Relationship to recipient

 self spouse/same-sex partner dependent child or dependent adult

**This section to be completed by one of the following: Physician, Registered Nurse in the Extended Class,
Registered Dietitian or Registered Midwife.**

Name

Address

Telephone number

Stamp

I am a legally qualified:

 Physician Registered Nurse in the Extended Class Registered Dietitian Registered Midwife

Signature:

Date

**In order for this form to be considered, the following pages must be completed by one of the
following approved health professionals:**

- Physician who is registered with the College of Physicians and Surgeons of Ontario.
- Registered Nurse in the Extended Class RN(EC) who is registered with the College of Nurses of Ontario.
- Registered Dietitian who is registered with the College of Dietitians of Ontario.
- Registered Midwife who is registered with the College of Midwives of Ontario. **Note: Midwives can only prescribe the following diets: Pregnancy Diet, Breastfeeding Diet and Infant Formula.**

Instructions for the approved health professional who is completing the following pages:

1. Place a check mark next to the diet(s) you are prescribing for the person applying for a special diet.
2. Indicate the length of time the diet is required.
3. Sign your name in the signature column provided next to each diet prescribed to certify that the individual requires a special diet(s) as a result of a medical condition(s) that you have documented.
4. Please make a photocopy of the completed form for your records.

**If you are a Registered Nurse in the Extended Class, Registered Dietitian or Registered Midwife,
please forward your invoice for \$20.00 to the local Ontario Disability Support Program office noted at the
top of the form, including the ODSP recipient's name and member ID.**

Diet Prescribed	Length of Time Diet is Required	Signature to Certify Person Requires a Special Diet as a Result of a Medical Condition
D <input type="checkbox"/> Diabetic Diet (includes low fat, high fibre and unsweetened products)	No Review	
<input type="checkbox"/> Gestational Diabetic Diet	During Pregnancy and Up to 3 Months Post-Delivery	
E <input type="checkbox"/> Enteral/Tube - Refer Person to the Ontario Drug Benefit Program	N/A	N/A
F <input type="checkbox"/> Fat/Cholesterol and/or High Fibre Diet	<input type="checkbox"/> 1 Year <input type="checkbox"/> 2 Years <input type="checkbox"/> Permanent	
G <input type="checkbox"/> Gluten Free	<input type="checkbox"/> 1 Year <input type="checkbox"/> 2 Years <input type="checkbox"/> Permanent	
I <input type="checkbox"/> Infant Formula Infants with prescriptions for the following formulas should be referred to the Ontario Drug Benefit Program administered by the Ministry of Health and Long-Term Care: Prescription for: -Alimentum Liquid -Neocate Powder -Nutramigen Liquid -Nutramigen Powder -PediaSure Liquid -Peptamen Junior Liquid -Portagen Powder -Pregestimil Powder -RCF Liquid -Resource Just For Kids -Vivonex Pediatric Powder An amount may be paid for only one of the following formulas, A or B for up to 12 months if the formula is prescribed for therapeutic purposes or if breastfeeding is contraindicated: Check A or B below: <input type="radio"/> A. Cow's milk-based formula <input type="radio"/> B. Soy-based formula only for vegan vegetarians or infants with galactosaemia	Maximum of 12 Months	Signature to certify that formula is required only for therapeutic purposes or if breastfeeding is contraindicated.
<input type="checkbox"/> Iron Rich Foods	<input type="checkbox"/> 1 Year <input type="checkbox"/> 2 Years <input type="checkbox"/> Permanent	
K <input type="checkbox"/> Ketogenic Diet	<input type="checkbox"/> 1 Year <input type="checkbox"/> 2 Years <input type="checkbox"/> Permanent	
L <input type="checkbox"/> Lactose Reduced Diet - Refer Person to the Ontario Drug Benefit Program	N/A	N/A
M <input type="checkbox"/> MCT Oil (Medium Chain Triglycerides) - Refer Person to the Ontario Drug Benefit Program	N/A	N/A
O <input type="checkbox"/> Organic Diet	<input type="checkbox"/> 1 Year <input type="checkbox"/> 2 Years <input type="checkbox"/> Permanent	
P <input type="checkbox"/> Phosphorous (Restrictions)	<input type="checkbox"/> 1 Year <input type="checkbox"/> 2 Years <input type="checkbox"/> Permanent	
<input type="checkbox"/> Pregnancy Diet Check A or B below: <input type="radio"/> A. Milk-based (Person is lactose tolerant) <input type="radio"/> B. Non-dairy (Person is lactose intolerant)	EDC Up To Deliver Date Only	
<input type="checkbox"/> Probiotics (addition of yogurt with active culture)	<input type="checkbox"/> 1 Year <input type="checkbox"/> 2 Years <input type="checkbox"/> Permanent	
<input type="checkbox"/> Protein (Restrictions) & Phosphorous (Restrictions)	<input type="checkbox"/> 1 Year <input type="checkbox"/> 2 Years <input type="checkbox"/> Permanent	
<input type="checkbox"/> Protein (High) Diet Extra calories/protein acquired through additional food sources other than prepared supplements, check one of the following: ___ less than 3000 kcal or 12600 kJ per day ___ greater than or equal to 3000 kcal or 12600 kJ per day	<input type="checkbox"/> 1 Year <input type="checkbox"/> 2 Years <input type="checkbox"/> Permanent	
<input type="checkbox"/> Prunes	<input type="checkbox"/> 1 Year <input type="checkbox"/> 2 Years <input type="checkbox"/> Permanent	
<input type="checkbox"/> Pureed Foods - One Time Amount Payable to Purchase Food Blender	N/A	N/A



	Diet Prescribed	Length of Time Diet is Required	Signature to Certify Person Requires a Special Diet as a Result of a Medical Condition
R	<input type="checkbox"/> Residue (Restrictions)	<input type="checkbox"/> 1 Year <input type="checkbox"/> 2 Years <input type="checkbox"/> Permanent	
S	<input type="checkbox"/> Sodium/Salt (Restrictions) Sodium requirements, check one of the following: <input type="checkbox"/> No added salt (3g or more) <input type="checkbox"/> 2g/87mEq or (2 - 2.9g) <input type="checkbox"/> 1g/43mEq or less (1.9g or less)	<input type="checkbox"/> 1 Year <input type="checkbox"/> 2 Years <input type="checkbox"/> Permanent	
	<input type="checkbox"/> Sugar Free/Unsweetened Products	<input type="checkbox"/> 1 Year <input type="checkbox"/> 2 Years <input type="checkbox"/> Permanent	
T	<input type="checkbox"/> Thickened Products	<input type="checkbox"/> 1 Year <input type="checkbox"/> 2 Years <input type="checkbox"/> Permanent	
V	<input type="checkbox"/> Vitamins/Minerals and Herbal Supplements	<input type="checkbox"/> 1 Year <input type="checkbox"/> 2 Years <input type="checkbox"/> Permanent	
X	<input type="checkbox"/> Special Diet Other Than Or In Addition To Diets Set Out Above, Except For Diets For Which No Amount Is Payable (see below). Note: No amount is payable for the following special diets: Chicken/Poultry Free; Corn Free; Fish Free; Food Colours Free; Histamines Free; Meat Free; Peanuts/Nuts/Legumes Free; Shellfish Free; Sulphites Free; Yeast Free; Balanced Diets/Diets as Tolerated; Bland Diet; Fluid (High); Folic Acid (High); General Diet for Weight-Reducing Purposes (Does not include morbid obesity); Potassium (High); Potassium (Restrictions); Protein (Restrictions) Diet; Purine (Restrictions); Reflux (Anti); Rotational Diet; No added salt (3g or more); Sports-Related Enhancement Products; Tyramine (Restrictions) and Vitamin K (Low).	Other Special Diets Will Be Reviewed Every 12 Months	Please provide details of the special diet required.

Notice with Respect to the Collection of Personal Information
(Freedom of Information and Protection of Privacy Act)

This information is collected under the legal authority of the *Ontario Disability Support Program Act, 1997*. The information will be used for the purpose of administering the Ontario Disability Support Program and providing income support. For more information, contact your nearest Ontario Disability Support Program office.

Contact Information: _____

Name: _____

Position: _____

Note: If the applicant appeals the decision, this and all supplementary medical information provided will be released to the applicant, their legal representative(s) and the Social Benefits Tribunal.