Erase Print Save

Santé et Services sociaux Québec

DT9494

Date of birth (Year / Month / Day)	Room No.	File No.
First and last names at birth		
Current (or spouse's) last name		
Address		
Postal Code	Telephone (Area code)	Sex: F ☐ M ☐
Health insurance No.	Attending physician	

CONSENT FOR PARTICIPATION IN THE QUÉBEC FOOD PROGRAM FOR THE TREATMENT OF INHERITED METABOLIC DISORDERS

The purpose of the **Québec Food Program for the Treatment of Inherited Metabolic Disorders** is to cover the cost of therapeutic nutritional products needed to treat inherited metabolic disorders. The primary objective is to ensure that people with inherited metabolic disorders who must follow a diet restricted in protein, fat, or carbohydrates have access to the therapeutic nutritional products prescribed to them, regardless of the health and social services region they live in.

A second objective is to relieve the financial burden on participants and their families.

In order to ensure that you have access to the products you need, we must share certain information about you with program providers. If you want to participate in the program, please read and fill out this form.

By participating in the program, you agree to have information about you sent to:

1. The institution in charge of the Québec Food Program for the Treatment of Inherited Metabolic Disorders, for administrative and medical follow-up
2. The person in charge of therapeutic nutritional product distribution at your local health and social services institution
3. The company that supplies the products, to ensure proper shipment. In this case, only the information marked with an asterisk (*) will be shared with the supplier.

If you agree to participate in the program, your consent can be withdrawn at any time. Likewise, if you decide not to take part now, you can change your mind at any time and give consent. To do so, simply contact your diagnosis and treatment center.

Rest assured that all your information will be treated confidentially.

Information

The following personal information will be shared for the purposes of the Québec Food Program for the Treatment of Inherited Metabolic Disorders:

*Participant's first and last names:	* Date of birth (Year / Month / Day)	Sex: ☐ F ☐ M
*Diagnosis		
Participant's street address, city, postal code		Area code Telephone
First and last name of the holder of parental authority, guardian, proxy, or curator		
Address of the holder of parental authority, guardian, proxy, or curator		Area code Telephone
Diagnosis and treatment centre (medical follow-up)	* Health and social services region of the local health facility	
* Address of the local health facility (delivery location), city, postal code		

Consent

☐ I agree to participate in the Québec Food Program for the Treatment of Inherited Metabolic Disorders. I understand and agree that the information in this form will be sent to the program providers indicated above.

Signature	(participant, holder of parental authority, guardian, proxy, or curator)	Date	Year / Month / Day

Ministère de la Santé et des Services sociaux