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 professional | |

# 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If you agree to participate in the program, your consent can be withdrawn at any time.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 | | OMIM No. |
| *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) | | |
| * Referral and treatment center address, 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