

Infant Formula Program Referral Form

The Infant Formula Program provides infant formula to birthing parents living with HIV.

Fax referral to: 204-318-3181

***Consult:** 1-866-449-0165

Today's date (dd/mmm/yyyy):		
PATIENT INFORMATION (birthing person living with HIV)		
Last name:	Street address:	
First name:	City/Town:	
MB Health #:	Postal code:	
PHIN:	Primary phone number:	
Date of birth (dd/mmm/yyyy):	Can we leave a confidential voice message: <input type="checkbox"/> Yes <input type="checkbox"/> No	
Expected due date of infant (dd/mmm/yyyy):	Preferred language:	
	Interpreter required: <input type="checkbox"/> Yes <input type="checkbox"/> No	
PHARMACY INFORMATION		
Name of pharmacy as indicated by patient:	Street address:	
Contact name:	City/town:	
Phone number:	Postal code:	
Fax Number:		
PROVIDER INFORMATION		
Referring site of care:		
Referring provider first and last name:	Phone number:	Fax number:
Primary care provider first and last name (if different from above):	Phone number:	Fax number:

12/2024

**The Manitoba HIV Program recommends primary care providers consult the Program when patients become pregnant.*