SUPPLEMENTARY WELFARE ALLOWANCE
ADULT DIET SUPPLEMENT

(S.W.A. 9 - October 2011)

To be used in conjunction with SWA 1

For Office Use
Date Received

By Whom

Information given will be treated as strictly confidential.

Please

- Use BLOCK LETTERS
- Have all Relevant Sections Completed

You **do not** have to complete this form if you have a Long-Term Illness Book **and** have Cystic Fibrosis **and** are prescribed a high protein, high calorie diet.
Please submit your Long-Term Illness Book with your application.

Section 1: To Be Completed by Applicant:

Name _____ Date of Birth: _____

Address _____ P.P.S. Number: | | | | | | | | | | |

_____

_____

I wish to claim a diet supplement from the Department of Social Protection. I request and authorise the appropriate authorised persons to complete Section 2 and Section 3.

Signed: _____ Date: _____

APPLICANT

Section 2: Certificate of Prescribed Medical Condition

A Hospital Consultant **or** Hospital Registrar may complete this section in respect of **all** Diets listed overleaf.

A General Practitioner may complete this section **in respect of a gluten free/coeliac diet only**.

I certify that _____ has been prescribed a specified diet(s) as part of his/her treatment for the following medical condition(s):

_____

Signed: _____ Official Stamp

Hospital Consultant/Hospital Registrar/General Practitioner
(Delete as appropriate)

Date: _____ Telephone Number: _____

Section 3: Type and Duration of Diet:

(To be completed by a Hospital Consultant, Hospital Registrar, General Practitioner or Qualified Dietician).

The following diet(s) has/have been prescribed (tick as appropriate):

1. **Low Lactose, Milk Free Diet** ☐
2. **Gluten Free Diet / Coeliac Diet** ☐
3. **High Protein, High Calorie Diet** ☐
4. **Altered Consistency (Liquidised) Diet** ☐

The duration of the diet is (please tick):

☐ Unlimited

☐ Restricted and is prescribed from (date) _____ To (date) _____

Signed: _____ **Official Stamp**
Hospital Consultant / Hospital Registrar / General Practitioner / Dietician
(Delete as appropriate)

Date: _____ Telephone No. _____

For Office Use Only

Signed: _____ Date: _____