Meals On Wheels Referral Intake Form

Referral Date & Time_____ Intake Staff_____

Name First_____ Middle Initial_____Last Name_____

Social Security#_____ Telephone#_____

Please Check One: HM ☐ UHC ☐ Title 3 ☐

Title 3 Referral:

Medicare/Medicaid #_____ Low Income Yes/ No

Mailing
Address:_____
_____

Home Address & Directions
_____
_____
_____
_____

Date of Birth_____ Age_____ Race_____

Single :_____ Married:_____ Divorced: _____Seperated:_____ Widowed:_____

Lives Alone:_____ With Spouse:_____ Other_____

Family or Support System:_____

Referral Source_____

Primary Care Physician:_____Phone #_____ Fax # _____

Requested Diet:_____Milk_____ Obtained by: Doctor, Hosp, Client Other circle one

Emergency Contact(1)_____ Phone _____ Relationship_____

Emergency Contact(2)_____ Phone_____ Relationship_____

Summary of Health Conditions, Environment, Support System, In Home Services Etc.

_____
_____
_____
_____
_____

Medical Alert:_____

Key Information_____

If Client Not Home_____

Outreach worker will call client within 5 working days of referral

Start Date_____
Discontinued Date _____
Restart Date _____