MEALS ON WHEELS SERVICES

Funded through Ryan White Supplemental Grant and the Indiana State Department of Health

Please call MOW Client Services with questions. Toll-free: (844) 935-9353 local: (317) 252-5558.
Referrals can be scanned and emailed to Nick Fennig at nfennig@mealsonwheelsindy.org,
faxed to (317) 252-5559 or mailed to Meals on Wheels at P.O. Box 40969, Indianapolis, IN 46240.

PLEASE COMPLETE IN ENTIRETY

Name (Print): _____ Date: __/__/__

RW Client ID # (if applicable): _____ RW Expiration Date: _____

Has client applied for Part A? YES NO N/A Has client applied for Part B? YES NO N/A

Address: _____ Apt. #: _____

City: _____ County: _____ State: _____ Zip: _____

Home Phone: ____-____-_____ Cell Phone: ____-____-____ DOB: __/__/__

CLIENT DEMOGRAPHICS

GENDER: □ Male □ Female Transgender: □ Male-to-Female □ Female-to-Male

RACE: □ African-American □ Caucasian/Non-Hispanic □ Hispanic □ Asian

□ Pacific Islander □ Native American □ Other: _____

CD4 Count: _____ Viral Load: _____ Height: _____ Weight: _____

Diabetes DX? YES NO A1C Level: _____ Hypertension DX? YES NO Blood Pressure: _____

HEALTH ISSUES: _____

MOBILITY ISSUES (factors that impact the client's ability to maintain an independent lifestyle):

_____

Is the client pregnant? (circle one) YES NO

EMERGENCY CONTACT INFORMATION

Name: _____ Relationship: _____

Phone (Day): ____-____-_____ (Evening): ____-____-_____

NUTRITION EDUCATIONAL MATERIALS SPECIFIC TO HIV – sent directly to client in food box

Please check here if client wishes to OPT OUT of receiving these HIV-specific materials ☐

REFERRING AGENCY INFORMATION

Referring Agency Name: _____ Contact Name: _____

Email Address: _____ Phone # ____-____-_____ Fax # ____-____-_____

MEDICAL INFORMATION & DIET ORDER

Patient/Client Name (Print): _____

Provider Name: _____ Phone #: ____-____-_____

Clinic Name (if applicable) _____ Practicing Hospital _____

Phone ____-____-_____ Ext. _____ Additional Phone ____-____-_____

Diet Order (check all that apply or write order below):

□ Regular Diet □ Renal □ Low Sodium □ Diabetic

_____

_____

DIETARY RESTRICTIONS: * All Meals on Wheels diets are Heart-Friendly**

□ No Dairy □ No Seafood □ No Red Meat □ Other _____

Does the client have any allergies/intolerances to food? _____

PROVIDER DIET ORDER

Provider's Signature* and Date: _____

***can be signed by medical staff functioning on behalf of a physician or nurse practitioner.**

***** Please note that Meals on Wheels cannot accommodate food *preferences* for daily meal delivery. Also, we cannot accommodate some food allergies. Our kitchens processes ingredients with common allergens such as wheat, egg, soy, dairy and others.**