MEALS ON WHEELS SERVICES

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

Please call MOW Client Services with questions: Local (317) 252 -5558 EXT. 2

Referrals can be scanned and emailed to ryansmeals@mealsonwheelsindy.org or faxed to (317) 252-5559.

PLEASE COMPLETE IN ENTIRETY

Client Name (Print):_____Date: _/___/_

Legal Name (if different from Client Name) _____

RWISEUID number:_____ Expiration/Re-Certification Date: _____

Address:_____Apt. #: _____

City:_____County:_____State:_____Zip: _____

Home Phone:_____Cell #:_____Email Address:_____DOB:_/____/_

Preferred method of contact (circle one): Phone# Email

EMERGENCY CONTACT INFORMATION (preferably close family member or friend)

Name:_____Relationship:_____

Phone (Day):_____(Evening):_____

CLIENT DEMOGRAPHICS

DESCRIPTOR: □ Cisgender □ Transgender

GENDER ID: □ Male □ Female □ Non-Binary □ Other: _____

Pronouns: _____

Do you have language barriers? _____

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

□ Pacific Islander □ Native American □ Biracial □ Other: _____

EDUCATION LEVEL: ☐ Less than high school ☐ High school/GED ☐ Some college ☐ Two-year degree ☐ Four-year degree ☐ Technical degree ☐ Master's degree ☐ Doctorate degree

EMPLOYMENT STATUS: ☐ Employed full-time (35+ hours) ☐ Employed part-time (<35 hours) ☐ Unemployed (seeking employment) ☐ Not in workforce (homemaker, disabled, retired, student, children)

REFERRING AGENCY INFORMATION

Referring Agency Name:_____ Care Coordinator Name: _____

Email Address: _____ Phone# _____ Fax# _____

MEDICAL INFORMATION

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

Diabetes DX? YES NO AlC 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

Is the client a Medicaid Waiver service recipient? Yes/ No

DIET ORDER

DOB:_____ Patient/Client Name (Print): _____

Provider Name :_____ Phone:_____ Fax:_____

Clinic Name (if applicable)_____ Practicing Hospital _____

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

☐ **Regular Diet** ☐ **Renal** ☐ **Low Sodium** ☐ **Diabetic**

Other diet: _____

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

☐ **Liquid Supplement Order:** Per Meals on Wheels Registered Dietitian recommendation

□ 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.