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 meals@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 AIC 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 *THIS SECTION MUST BE FILLED OUT IN ITS ENTIRETY; NO EXCEPTIONS

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* for daily meal delivery, along with some food allergies. Our kitchens processes ingredients with common allergens such as wheat, egg, soy, dairy and others.

***IF CHECKING BOX BELOW, FILL OUT SUPPLEMENT ORDER ON PAGE 3**

☐ **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.

LIQUID SUPPLEMENT ORDER
**All liquid supplement orders are reviewed by MOWCI's RD. Ensure scripts are only good for six months, at which point an updated Diet Order and Ensure script must be sent to the client's appropriate Client Services Coordinator (CSC) at MOWCI.*

Liquid supplement order – supplement type: (check only ONE box)

☐ **Ensure** ☐ **Ensure Plus** ☐ **Glucerna** ☐ **Powdered Ensure**

Liquid supplement flavor: (check all that apply)

☐ **Butter Pecan** ☐ **Vanilla** ☐ **Strawberry** ☐ **Chocolate**

Liquid supplement amount:

__________cans per day OR ___________cases per month