# 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.

**Incomplete referrals will be returned to the sender.**

**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**

**Allergies / Restrictions:**

☐ 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.