Referral Instructions

Please read all referral instructions to ensure correct completion and submission of a referral.

All sections that apply to the referral illness must be completed concisely and clearly.

All supporting documents that are required for the referral diagnosis must be submitted before service can begin.

Eligibility Criteria:

All referrals must have a qualifying illness or be receiving hospice care; a compromised nutritional status AND require assistance with at least one activity of daily living.

<table>
<thead>
<tr>
<th>Referral Illness</th>
<th>Compromised Nutritional Status</th>
<th>Activity if Daily Living</th>
</tr>
</thead>
<tbody>
<tr>
<td>HIV/AIDS</td>
<td>Chewing Difficulty</td>
<td>Ambulation</td>
</tr>
<tr>
<td>Cancer (active treatment)</td>
<td>Swallowing Difficulty</td>
<td>Bathing</td>
</tr>
<tr>
<td>Stage 5 Renal Disease</td>
<td>Diarrhea (Persistent and lasting more than one month)</td>
<td>Decision Making</td>
</tr>
<tr>
<td>Congestive Heart Failure</td>
<td>Nausea (lasting longer than 2 weeks)</td>
<td>Grocery Shopping</td>
</tr>
<tr>
<td>COPD</td>
<td>Vomiting (lasting more than 2 weeks)</td>
<td>Homemaking</td>
</tr>
</tbody>
</table>
| Multiple Sclerosis (RRPS, SPMS, or PPMS) | Involuntary weight loss (>
 | | >5% in 4 weeks’ time or >10% in 6 months’ time) | Meal Preparation |
| Amyotrophic Lateral Sclerosis/Lous Gehrig’s Disease (ALS) Middle or Late Stages | | Transferring |
| Parkinson’s Disease (Stage III, IV, or V) | | |
| Diabetes         | | |

Completed Forms:

Email: intake@foodandfriends.org

Mail: Client Services
219 Riggs Rd NE
Washington, DC 20011

Fax: 202-635-4261
Attn: Food & Friends
Client Services

Questions:
Please call
202-269-6820

Revised 10/2020
Please print clearly and complete fully. Incomplete forms will not be accepted.

Client Name First: ____________ Middle: ____________ Last: ____________

Date of Birth: ____________ Received Food and Friends services previously? ☐ Yes ☐ No

Client Email Address: ________________________________

Client Home Address: __________________________________________

City: __________________________ State: __________________ Zip Code: ____________

DC Ward: ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ N/A

Cell Phone: __________________________ Secondary Phone: __________________

Does client consent to receive text message alerts about deliveries? ☐ Yes ☐ No

Referring Agency: Provider Agency: __________________________________________

Provider Address: __________________________________________

Demographic Information (ALL FIELDS ARE REQUIRED)

Gender: ☐ Female ☐ Male ☐ Trans Female ☐ Trans Male ☐ Other: ____________

Ethnicity: ☐ Hispanic/Latino ☐ Non-Hispanic/Latino ☐ Refused

Race: ☐ American Indian/Alaskan Native ☐ Asian ☐ Black/African-American

☐ Native Hawaiian/Pacific Islander ☐ White/Caucasian ☐ Other: ____________

Veteran: ☐ Yes ☐ No ☐ Don’t Know ☐ Refused

Primary Language: ____________ Fluent in English? ☐ Yes ☐ No
Services Needed/Treatment Plan (ALL FIELDS ARE REQUIRED)

- Home-Delivered Meals (6, 12, or 18 frozen prepared meals)
- Groceries-to-Go (shelf-stable items, frozen proteins, and fresh produce)

**Meal Plan:** (choose up to 2)
- Regular
- Renal
- Diabetic
- No Fish
- Vegetarian
- Heart Healthy
- GI Friendly
- No Dairy
- Shelf Stable

**Texture:** (Optional)
- Pureed
- Soft

**Dietary Restrictions/Food Allergies**

*Please inform us of any food allergies as our meals and groceries do not have allergy-free options.*
*Meals may contain the following: milk, egg, fish, shellfish, tree nuts, wheat, peanuts, or soy.*

Does the client have a microwave?  Yes ☐  No ☐

### Household and Family Information (ALL FIELDS ARE REQUIRED)

Client lives: (check one)
- Alone
- with Partner/Family
- with Friends
- In shelter/homeless
- other (please describe): ____________________

Total Number of Household Members: ____________  Household and Family members:
1. Name: ______________________ DOB: ______________ Gender: ______________
   Relationship to Client: _______ Ethnicity: ______________ Race: ______________
   Primary Language: ______________ Needs Food & Friends Services: ☐ Yes ☐ No
2. Name: ______________________ DOB: ______________ Gender: ______________
   Relationship to Client: _______ Ethnicity: ______________ Race: ______________
   Primary Language: ______________ Needs Food & Friends Services: ☐ Yes ☐ No

Will the client receive deliveries at the home address on Page 1?  ☐ Yes ☐ No

If NO, please provide the address where deliveries should be made:

**Delivery Address:** ___________________________________________________________

City: ______________________ State: ______________ Zip Code: ________________

Revised 10/2020
## Providers and Relationships (REQUIRED if applicable)

### Case Manager:
- Name: ______________________
- Organization: ______________________
- Phone: ______________________
- Email: ______________________
- Aware of client’s illness/status? □ Yes □ No
- Emergency Contact? □ Yes □ No
- Referring Provider? □ Yes □ No

### Physician:
- Name: ______________________
- Organization: ______________________
- Phone: ______________________
- Email: ______________________
- Aware of client’s illness/status? □ Yes □ No
- Emergency Contact? □ Yes □ No
- Referring Provider? □ Yes □ No

### Other:
- Name: ______________________
- Organization: ______________________
- Phone: ______________________
- Email: ______________________
- Relationship to Client: _____________
- Aware of client’s illness/status? □ Yes □ No
- Emergency Contact? □ Yes □ No
- Referring Provider? □ Yes □ No

### Emergency Contact:
- Name: ______________________
- Relationship to client: _________________
- Phone: ______________________
- Email: ______________________
- Aware of client’s illness/status? □ Yes □ No

## Income and Insurance information (REQUIRED)

### Income sources: Please list all sources and amount; (SNAP, TANF, and/or WIC if applicable)
- Income Source #1: ______________________ Amount #1: ______________________
- Income Source #2: ______________________ Amount #2: ______________________
- Income Source #3: ______________________ Amount #3: ______________________

If client has no income, please check this box □

(if income documentation is a requirement send case manager affidavit of no income)

Total Monthly Household Income: $ ______________________ per ______________________

### General Medical Insurance:
- Insurance Type #1: ________________ Carrier #1: ________________ Primary □ Yes □ No
- Insurance Type #2: ________________ Carrier #2: ________________ Primary □ Yes □ No

If client has no insurance, please check this box □
CLIENT TYPE A/B: HIV/AIDS (All Fields Required if Applicable)

☐ N/A

(must send proof of residency, proof of income, current CD4/Viral Load lab results, and insurance information)

<table>
<thead>
<tr>
<th>Lab</th>
<th>Value</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>CD4</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Viral Load</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

(Please attach matching lab report that is less than 6 months old as proof of HIV status)

Date of HIV Diagnosis: ___/___/___

CDC Defined AIDS? ☐ Yes ☐ No

Date of AIDS Diagnosis: ___/___/___

Mode of HIV Transmission (REQUIRED)

☐ Perinatal ☐ Blood transfusion ☐ MSM ☐ IV Drug Use ☐ Heterosexual Contact

☐ Hemophilia/Coagulation Disorder ☐ Not reported/Unknown

Supporting documents: Send proof of income, current CD4, Viral Load, and insurance information

CLIENT TYPE C: Active Cancer (All Fields Required if Applicable)

☐ N/A

Type: __________________________ Stage: ____ Date of most recent diagnosis: __________________________

Has primary cancer metastasized? Yes ☐ No ☐ Sites: __________________________

Active Treatment: (check those that apply)

☐ Radiation Therapy ☐ Chemotherapy ☐ Immunotherapy

Treatment Start Date: __________________________ Last Treatment Date: __________________________

☐ Bone Marrow/Stem Cell Transplant ☐ Hospice ☐ Maintenance Therapy

(Clients under maintenance therapies do not qualify for services)
<table>
<thead>
<tr>
<th>CLIENT TYPE D: Hospice (All Fields Required if Applicable)</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐ N/A</td>
</tr>
<tr>
<td>Is client currently under care of Hospice?  ☐ Yes  ☐ No</td>
</tr>
<tr>
<td>Admitting Diagnosis: ___________________________________</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>CLIENT TYPE E: Adult Diabetes (All Fields Required if Applicable)</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐ N/A</td>
</tr>
<tr>
<td>Diabetes (Adult) (must have A1C &gt;8%; Must send A1C lab results from within the last 3 months)</td>
</tr>
<tr>
<td>HbA1C:  Value____________________ Date________________________</td>
</tr>
<tr>
<td>Presence of Severe Complication (must have at least one):</td>
</tr>
<tr>
<td>☐ Heart failure  ☐ Chronic Kidney Disease (Stage IV-V)  ☐ Loss of vision/legal blindness</td>
</tr>
<tr>
<td>☐ Vascular complications (such as diabetic peripheral angiopathy with gangrene)</td>
</tr>
<tr>
<td>☐ Cerebrovascular disease (such as stroke within the last year and/or vascular dementia)</td>
</tr>
<tr>
<td>☐ Obesity (BMI of 30.0 or greater)</td>
</tr>
<tr>
<td>supporting documents: Send A1C lab results dated within the last 3 months</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>CLIENT TYPE F: Pediatric Diabetes (All Fields Required if Applicable)</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐ N/A</td>
</tr>
<tr>
<td>Diabetes (Pediatric; age 2-18) - Must send A1C lab results from within the last 3 months)</td>
</tr>
<tr>
<td>☐ Type I (must have A1C &gt; 11.5%)  HbA1c: Value: _______ Date: _______</td>
</tr>
<tr>
<td>Hospitalized for Ketoacidosis in the last 6 months?  ☐ Yes ☐ No  Date: ______________</td>
</tr>
<tr>
<td>☐ Type II (must have A1C &gt; 7.5%)  HbA1c: Value: _______ Date: _______</td>
</tr>
<tr>
<td>BMI is greater than the 95th percentile  ☐ Yes ☐ No</td>
</tr>
<tr>
<td>supporting documents: Send A1C lab results dated within the last 3 months</td>
</tr>
</tbody>
</table>
CLIENT TYPE G: Life-Challenging Illness (All Fields Required if Applicable)

- N/A
- **Stage 5 Renal Disease** Dialysis Schedule: _________________ Dialysis Center: _________________
- Congestive Heart Failure NYHA Class III or IV
- Chronic Obstructive Pulmonary Disease Stage III or IV
- Multiple Sclerosis RRPS, SPMS, or PPMS
- ALS (Amyotrophic Lateral Sclerosis/Lou Gehrig's disease) Middle or Late Stage
- Parkinson’s Disease Stage III, IV, or V

### Additional Health Information (for Nutrition Assessments)

Is client being seen by a Dietitian/Nutritionist?  □ Yes □ No
If yes:  Name ________________________________  Agency: __________________________________________
        Phone: ________________________________  Email: __________________________________________

Pregnancy Status:  □ Yes □ No □ Unknown

Previous Hospitalizations:

<table>
<thead>
<tr>
<th>Admit Date</th>
<th>Hospital/Reason</th>
<th>Discharge Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>_______</td>
<td>_______________</td>
<td>______________</td>
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<td>_______</td>
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<tr>
<td>_______</td>
<td>_______________</td>
<td>______________</td>
</tr>
</tbody>
</table>

Past Medical History (Ex: Diabetes, Hyperlipidemia, Hypertension, CKD, Cancer, etc): __________________________

Medication/Supplements: ______________________________________________________________________________
_____________________________________________________________________________________________________

Additional Psychosocial Information: ________________________________________________________________
___________________________________________________________________________________________________

Revised 10/2020
Activities of Daily Living (REQUIRED)

Must be deficient in at least one ADL (please check all that apply):

<table>
<thead>
<tr>
<th>Activity</th>
<th>Independent</th>
<th>With difficulty</th>
<th>Some Assistance</th>
<th>Total Assistance</th>
<th>Who Assists</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ambulation</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Bathing</td>
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<td></td>
</tr>
<tr>
<td>Decision Making</td>
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</tr>
<tr>
<td>Dressing</td>
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<tr>
<td>Eating</td>
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<tr>
<td>Grocery Shopping</td>
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<tr>
<td>Homemaking</td>
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</tr>
<tr>
<td>Meal Preparation</td>
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<tr>
<td>Toileting</td>
<td></td>
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<td></td>
</tr>
<tr>
<td>Transferring</td>
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</tbody>
</table>

Notes:

Compromised Nutritional Status (REQUIRED)

☐ Chewing Difficulty
☐ Swallowing Difficulty
☐ Diarrhea (persistent and lasting more than one month)
☐ Nausea (lasting longer than 2 weeks)
☐ Vomiting (lasting more than 2 weeks)
☐ Inability to procure/prepare food due to health reasons (MUST SPECIFY):
☐ Involuntary weight loss (>5% in 4 weeks’ time or >10% in 6 months’ time)

Height and Weight Information (REQUIRED); if unknown use last known information

Height: ________________(in/cm) Weight: ________________(kg/lb) Usual Weight: ________________(kg/lb)

Weight loss ☐ Yes ☐ No Amount: ________________ Length of time: ________________ Date: __________
I, the undersigned, do attest that my client, ___________________________, meets the Food and Friends eligibility requirements. I have verified these eligibility requirements including medical status.

Referring Party Name: ___________________________ Title: ___________________________

Organization: __________________________________________________________________________

Signature: ___________________________ Date: ___________________________