



Reason: _____

Nutrition Referral/Assessment for Home Delivered Meals

This form must be completed and forwarded to the appropriate Home Delivered Meal nutrition provider agency.

Referral Source: <input type="checkbox"/> Care Coordination Unit (CCU) _____			
<input type="checkbox"/> Managed Care Organization (MCO) _____			
<input type="checkbox"/> Area Agency on Aging		<input type="checkbox"/> Nutrition Provider	
Days Older Adult to Receive Meals (Check all that apply): <input type="checkbox"/> Mon <input type="checkbox"/> Tues <input type="checkbox"/> Wed <input type="checkbox"/> Thurs <input type="checkbox"/> Friday			
<input type="checkbox"/> All M-F <input type="checkbox"/> Weekend <input type="checkbox"/> 2nd meals			
Type of Meal(s): <input type="checkbox"/> Hot <input type="checkbox"/> Cold <input type="checkbox"/> Frozen		Special Notes:	
Priority Level: <input type="checkbox"/> High <input type="checkbox"/> Intermediate <input type="checkbox"/> Low			
Duration of meals (Check only one): <input type="checkbox"/> Short Term <input type="checkbox"/> Long Term Re-evaluate Date: _____			
Special Diet Needs: <input type="checkbox"/> General <input type="checkbox"/> Diabetic <input type="checkbox"/> Low sodium <input type="checkbox"/> Other (specify): _____			
Older Adult Demographic Information			
Name: _____		DOB: _____	
Address: _____		City: _____	State: _____
Phone: _____		Cell Phone: _____	
Authorized Representative: _____		Phone: _____	
Emergency Contact Name #1: _____		Emergency Contact Name #2: _____	
Relationship: _____		Relationship: _____	
Daytime/Cell Phone: _____		Daytime/Cell Phone: _____	
Ethnicity: <input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino	What is your gender? (Check only one) <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Other	Marital Status: <input type="checkbox"/> M <input type="checkbox"/> D <input type="checkbox"/> S <input type="checkbox"/> W <input type="checkbox"/> Domestic Partner <input type="checkbox"/> Legally Separated	Type of Housing: <input type="checkbox"/> Home <input type="checkbox"/> Apt (# : _____) <input type="checkbox"/> Other (specify): _____
Race (Check all that apply): <input type="checkbox"/> White <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Pacific Islander <input type="checkbox"/> American Indian or Alaskan Native <input type="checkbox"/> Asian or Asian American	Are you a Veteran? <input type="checkbox"/> Yes <input type="checkbox"/> No		Subsidized Housing: <input type="checkbox"/> Yes <input type="checkbox"/> No
Below Poverty? <input type="checkbox"/> Yes <input type="checkbox"/> No	Monthly Income: _____	# of Individuals in Household: _____	
Limited English Speaking: <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, primary language spoken: _____			

Nutrition Risk Screen (circle points under Yes or No)	Yes	No
I have an illness or condition that has made me change the kind or amount of food I eat.	2	0
I eat less than two meals a day.	3	0
I eat few fruits and vegetables, or milk products.	2	0
I have three or more drinks of beer, liquor, or wine almost every day.	2	0
I have tooth or mouth problems that make it hard for me to eat.	2	0
I don't always have enough money to buy the food I need.	4	0
I eat alone most of the time.	1	0
I take three or more different prescribed or over-the-counter drugs a day.	1	0
Without wanting to, I have lost or gained ten pounds in the last six months.	2	0
I am not always physically able to shop, cook, and/or feed myself.	2	0
TOTAL		

Six or more points = High Nutritional Risk

Nutritional Risk was explained to client.

Client is considered at High Nutritional Risk. A recommendation was made to follow-up with a healthcare provider.

Impairment/Problem with Activity of Daily Living 0 No Assist = No; 1-3 Assist = Yes; 4 Unknown = No			Impairment/Problem with Instrumental Activities of Daily Living 0 No Assist = No; 1-3 Assist = Yes; 4 Unknown = No		
	PTS	Yes/No		PTS	Yes/No
Eating			Laundry		
Bathing			Shopping		
Grooming			Light Housework		
Dressing			Heavy Housework		
Toileting			Telephone		
Walking/Mobility			Financial Management		
Transferring (in/out of bed/chair)			Transportation		
			Meal Preparation		
			Medication		
Total Points			Total Points		
Total "Yes"= _____ Total "No"= _____			Total "Yes"= _____ Total "No"= _____		

Additional Nutrition Information	
Who does the grocery shopping? _____ How often? _____	Can Older Adult feed self? <input type="checkbox"/> Yes <input type="checkbox"/> No If no, who assists? _____ What type of help: <input type="checkbox"/> Cutting <input type="checkbox"/> Feeding <input type="checkbox"/> Opening Containers
Is anyone available to prepare food? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, who? _____ What days? _____ Which meals? _____	Does Older Adult have difficulty chewing/poor dental health? <input type="checkbox"/> Yes <input type="checkbox"/> No
Older Adult's kitchen facilities/equipment (Check all that apply): <input type="checkbox"/> Kitchen <input type="checkbox"/> Kitchen privileges <input type="checkbox"/> Freezer w/ available space <input type="checkbox"/> Refrigerator <input type="checkbox"/> Stove <input type="checkbox"/> Microwave	Is Older Adult able to use these appliances unsupervised (Check all that apply): <input type="checkbox"/> Stove <input type="checkbox"/> Microwave <input type="checkbox"/> Freezer <input type="checkbox"/> Refrigerator
Older Adult food source for the weekends:	Dietary restrictions:
Food Allergies: <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, specify: _____	
NOTE: It is the client's responsibility to review the weekly menu and bring any allergy concerns to the attention of the nutrition provider. When feasible, the provider will supply a special meal to meet the dietary needs of the client.	
Are you currently receiving food assistance benefits? <input type="checkbox"/> Yes <input type="checkbox"/> No (Examples: SNAP, SFMNP, TEFAP)	
Reason/Eligibility for Home Delivered Meals: (Check all that apply) <input type="checkbox"/> Homebound <input type="checkbox"/> Permanently disabled <input type="checkbox"/> Temporarily Disabled <input type="checkbox"/> Respite for Caregiver <input type="checkbox"/> Meal for Spouse or Disabled Adult in Home <input type="checkbox"/> Other (specify): _____	
Older Adult will benefit from Home Delivered Meals because (Check all that apply): <input type="checkbox"/> Older Adult has difficulty cooking, tires easily <input type="checkbox"/> Older Adult is recovering from surgery, illness, etc. <input type="checkbox"/> Meals will increase nutritional intake as Older Adult has a limited income <input type="checkbox"/> Other (specify): _____	
Currently receiving home delivered meals from another source (e.g. family, church, etc.): <input type="checkbox"/> Yes <input type="checkbox"/> No	
Major Health Problems (check all that apply)	
Ambulation: <input type="checkbox"/> Full <input type="checkbox"/> Partial <input type="checkbox"/> Assisted <input type="checkbox"/> Bedfast	Determination of Need (DON) score: (If Known) _____ Other major health concerns (describe): _____ _____ _____
Vision: <input type="checkbox"/> Full <input type="checkbox"/> Limited <input type="checkbox"/> Glasses <input type="checkbox"/> Blind	
Hearing: <input type="checkbox"/> Full <input type="checkbox"/> Hard of Hearing <input type="checkbox"/> Hearing Aid <input type="checkbox"/> Deaf	

