INTAKE INFORMATION

A. Person's Name: _____

B. Address: _____

C. Phone # _____ DOB/Age _____

D. Date of Referral: ____/____/____

VETERAN? YES NO
FRAIL/DISABLED? YES NO
LIVES ALONE? YES NO
ETHNICITY _____

E. Referral Source (specify Name, Agency, Phone): _____

_____

F. Presenting Problem/Person's Co ncern(s): _____

_____

G. Has this person ever received meals from us? YES NO If YES, when? _____

H. Does the person know that a referral has been made? YES NO If not, why?
_____
How long do you anticipate the meals will be needed?_____

I. Emergency Contact:
Name: _____ Phone: _____

Address: _____ Relationship: _____

J. Doctor's Name: _____

K. Dietary Restrictions:

None Diabetic Low Salt Other: _____

L. Has a physician prescribed this special diet? YES NO

M. Meal Plan: M-F weekend – frozen_____

N. Start Date: _____

O. Assessment Date: _____

P. Six month contact due date:_____

Directions to house: _____

_____

_____

Intake Worker's Name _____ Animals_____