Meals on Wheels
OF RHODE ISLAND

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Home Delivered Client Referral

70 Bath Street, Providence, RI 02908 p- (401) 351-6700 f-(401) 351-6750

CLIENT INFORMATION			
Name *(First, MI & last):* ☐ M ☐ F		**Birthdate:**	
Street Address:		**Soc. Sec. # Medicaid #**	
Address 2: *complex name, etc.*		**Bldg./Apt. #**	
City:		**Zip Code:**	
Home Phone:		**Cell Phone:**	
Email:		**Preferred Language:**	
Marital status: ☐ Single ☐ Partnered ☐ Married ☐ Separated ☐ Divorced ☐ Widowed			
Race/Ethnicity: ☐ White ☐ Black ☐ Hispanic ☐ American Indian ☐ Asian/Pacific Islander ☐ Other			
Veteran Status: ☐ Yes ☐ No	**Living Situation:**	☐ Alone ☐ With spouse ☐ With Child ☐ With Other # of people in house____	

PERSONAL HEALTH HISTORY				
Difficulties in: ☐ Hearing ☐ Sight ☐ Speech ☐ Mobility **If √, explain:**				
Medical Conditions: Please check all that apply	☐ Cancer	☐ Heart Disease	☐ Mental Health/Psychological Issue	☐ Renal/Kidney Issue
	☐ Depression	☐ Lung Disease	☐ Osteoporosis/Arthritis	☐ Stroke
	☐ Diabetes	☐ Memory Issue	☐ Parkinson's	☐ Weight Loss/Malnutrition

List any other medical problems

Why do you need Home Delivered Meals? (Please explain any difficulty with meeting your daily needs.)

Primary Doctor		**Phone Number**	

EMERGENCY CONTACT			
Name *(First & last):*		**Relationship:**	
Street Address:		**Zip Code:**	
City:		**Email:**	
Phone Number:	**Alternate Phone Number:**		

SECOND EMERGENCY CONTACT			
Name *(First & last):*		**Relationship:**	
Agency *(if applicable)*			
Street Address:		**Zip Code:**	
City:		**Email:**	
Phone Number:	**Alternate Phone Number:**		
Follow up with: ☐ Client ☐ Emergency Contact ☐ Second Emergency Contact ☐ Other			

Name of Primary Care Doctor & Phone Number_____

_____

Person Making Referral & Phone Number_____

Agency or Relationship to Client _____

Please answer each question below indicating one of the following responses:
0 = Can perform with NO ASSISTANCE
1 ==Can perform with SOME ASSISTANCE (uses a cane, needs help with meds, has an aide in home)
2 = Can perform with MUCH ASSISTANCE (uses a walker/wheelchair, needs assistance with bathing, dressing, meds, shopping)
3 = CANNOT PERFORM (unable to perform at all)

ACTIVITIES OF DAILY LIVING

	None	Some	Much	Cannot
Get in and out of bed/chair	0 __	1 __	2 __	3 __
Move about in the home	0 __	1 __	2 __	3 __
Dress oneself	0 __	1 __	2 __	3 __
Feed oneself	0 __	1 __	2 __	3 __
Use the toilet	0 __	1 __	2 __	3 __
Tend to personal hygiene	0 __	1 __	2 __	3 __
Prepare Nutritional meals	0 __	1 __	2 __	3 __
Perform light housekeeping	0 __	1 __	2 __	3 __
Perform heavy chores	0 __	1 __	2 __	3 __
Manage Medications	0 __	1 __	2 __	3 __
Manage finances	0 __	1 __	2 __	3 __
Use the telephone	0 __	1 __	2 __	3 __
Shop for oneself	0 __	1 __	2 __	3 __
Drives or utilizes public transportation	0 __	1 __	2 __	3 __

Please answer the following questions with Yes or NO

Do you drive? Yes___ No___

Do you have an illness/condition that may change the kind and or amount of food you eat Yes___ No___

Do you eat fewer than 2 meals per day Yes___ No___

Do you eat few fruits, vegetables or milk products Yes___ No___

Do you have 3 or more alcoholic drinks every day Yes___ No___

Do you have teeth/mouth problems that make it difficult for you to eat Yes___ No___

Do you always have enough money to buy the food you need Yes___ No___

Do you eat alone most of the time Yes___ No___

Do you take 3 or more medications each day Yes___ No___

Have you lost or gained 10 pound or more in the past 6 months Yes___ No___

Are you physically able to shop, cook and/or feed oneself Yes___ No___

Do you have difficulty getting out unless transportation is provided Yes___ No___

Do you lack outside activity Yes___ No___