COMMUNITY SERVINGS
FOOD HEALS

Date: _____

Covid Response: Medically-Tailored Home Delivered Meals Referral Form

This is the referral form for the 1-month meal program for people who are COVID positive or presumed positive, at high-risk for COVID-19, or are post-discharge due to COVID-19. Please complete form and submit via instructions below.

Member Information

_____
First and Last Name Date of Birth

_____
Address (Include Apartment Number)

_____
City State Zip Code

_____
Primary Phone Number Primary Language

_____
Delivery Directions *(for example: call cell phone upon arrival, doorbell is out of service)*

DIAGNOSIS (*check all that apply*)

- ❑ COVID-19 newly diagnosed positive or presumed positive
- ❑ High risk for COVID-19
- ❑ COVID-19 post-discharge
- ❑ CKD (stage): _____
- ❑ Diabetes **HgbA1c:** _____ *(if available)*
  - □ Type II □ Type I

TYPE OF DIET (***Note**: Some meal combinations may not be possible.)*

Choose 1:

- ❑ Wellness – general healthy diet
- ❑ Diabetic
- ❑ Cardiac
- ❑ Renal – kidney and diabetic friendly
- ❑ Children's wellness

AND

Choose up to 2 if needed:

- ❑ Vegetarian – no meat, chicken or fish
- ❑ Pescetarian – no meat or chicken (fish included)
- ❑ Mild – low in spice and acid
- ❑ Soft
- ❑ Low fiber
- ❑ Low lactose
- ❑ High calorie/protein
- ❑ No nuts
- ❑ No red meat
- ❑ No fish

Milk: ❑ Skim/nonfat ❑ 1% ❑ 2% ❑ Skim Lactaid

❑ Food Allergies: _____

PERSONS IN HOUSEHOLD *In addition to the primary client, Community Servings will provide meals to a caregiver and any children under the age of 18 in the household.*

Relationship	Diet Selection (see above)	Race	Gender	Date of Birth

FOOD STORAGE AND COOKING RESOURCES *(check all that apply)*

Meals recipient will have access to:

- ❑ Refrigerator
- ❑ Stove
- ❑ Microwave
- ❑ Oven
- ❑ Freezer
- ❑ None

ADDITONAL INFORMATION

Housing

- ❑ Permanent Housing
- ❑ Transitional Housing
- ❑ Emergency Shelter
- ❑ Temporarily living w/ friend/family
- ❑ Other (please specify:_____

Gender

- ❑ Female
- ❑ Male
- ❑ Transgender, Female to Male
- ❑ Transgender, Male to Female
- ❑ Other, Not Disclosed

Race/Ethnicity

- ❑ African American
- ❑ Asian
- ❑ American Indian or Alaska Native
- ❑ Hispanic or Latino/a
- ❑ Native Hawaiian or Pacific Islander
- ❑ White
- ❑ Other

REFERRAL CONTACT INFORMATION (person completing this form)

_____

Name Title

_____

Phone Number Email

May we contact you regarding any issues that may arise concerning this client? □ YES □ NO

I certify that the information here is accurate, that I have spoken with this patient and that they have agreed to be contacted by and receive services from Community Servings. □ YES □ NO

_____

Signature and Date

Please submit completed referral form to secure fax: 617.522.7770

Questions? Call 617-522-7777 to speak with a member of the Client Services team.