Please email completed form to office@mowih.org or Fax to 908-284-0708

Days of Meal Delivery
Weekday: M T W Th F
Weekend: Saturday / Sunday

CONFIDENTIAL

MEALS ON WHEELS IN HUNTERDON, INC.

HOME DELIVERED CLIENT REFERRAL FORM

Need Cooler/insulated bag: Yes No		Need Ice pack: Yes No	
Diabetic: Yes No		**Food Allergy:**	**MILK: 2% / Skim / Whole**

Telephone: _____ Date of Referral: _____ Initiate: _____

Name: _____
Last First

Address: _____
Street City Zip

ANY PETS? /No _____

Directions: _____

Birthdate: _____ Lives Alone: _____ Veteran: _____

Gender: ____ Male ____ Female Gender Identity: M / F

Ethnicity/Race: _____ White _____ Asian

_____ Hispanic/Latino _____ African American _____ Other

Emergency #1 Name: _____ Relationship: _____

Tel #: Home: _____ Work: _____ Cell: _____

Emergency #2 Name: _____ Relationship: _____

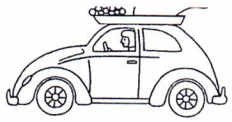
Tel #: Home: _____ Work: _____ Cell: _____

Do you lack money to buy food? Yes/No Suggested Donation: $5.50 / Other: _____

Poverty Status: $15,060 for 1 person / $20,440 for 2 persons / MEDICAID-MLTSS

Send Statement to:
Name: Client / Other _____

Address: _____



NUTRITION SCREENING

A. INTAKE

Name: (Last) _____ (First) _____ Phone No. _____

Date of birth: _____ Height: _____ Weight: _____

Referral Source: Self / Family / Friend / Hospital / Caregiver / Agency / Other

Are you able to leave your home without assistance? Yes/No Kind of Diet: Regular/Special

B. NUTRITION SCREEING INITATIVE

	No	Yes	Score
1. Do you eat *fewer* than 2 meals per day?			3
2. Do you eat alone most of the time?			1
3. Do you eat fewer than 2 servings of milk or milk products every day?			1
4. Do you eat fewer than 5 servings of fruits and/or vegetables every day?			1
5. Do you have 3 or more drinks of beer, liquor or wine most days?			2
6. Without wanting to, have you *lost or gained* 10 pounds in the last 6 months? Yes Gained _____ Yes Lost _____			2
7. Do you have an illness or health condition that made you change the kind or amount of food that you eat? Specify: _____			2
8. Do you take 3 or more different prescribed or over-the-counter drugs a day?			1
9. Are you not always physically able to shop, cook and/or feed yourself (or get someone to do it for you)?			2
10. Do you have problems with your teeth or mouth that makes it hard to eat?			2
11. Do you sometimes run out of money to buy the food you need?			4
(Tally the yes column. Score: 0-2 good; 3-5 moderate; 6 or more high nutritional risk.) ***TOTAL***			
C. Malnutrition Screening: 1. Have you recently lost weight without trying?			
1A. If Yes, how much weight have you lost? ☐ 2-13 lbs. (Score 1) ☐ 14-23 lbs. (Score 2) ☐ 24-33 lbs. (Score 3) ☐ 34 lbs. or more (Score 4) ☐ Unsure (Score 2) 1B. **Weight Loss Score**			
2. Appetite: Have you been eating poorly because of a decreased appetite? No (Score 0) Yes (Score 1)			

3. Total Score for questions 1 and 2	
D. **Food Insecurity** 1. Within the past 12 months, I worried whether my food would run out before I got money to buy more.	Never _____ Sometimes ___ Often _____
2. Within the past 12 months, the food I bought just didn't last and I didn't have money to buy more?	Never _____ Sometimes ___ Often _____

IMPAIRMENTS *(check all that apply)*

ACTIVITIES OF DAILY LIVING	*INSTRUMENTAL ACTIVITIES OF DAILY LIVING*
1. Bathing _____	*1. Preparing Meals* _____
2. Dressing _____	*2. Ordinary Housework* _____
3. Eating _____	*3. Laundry* _____
4. Walking/Transferring _____	*4. Shopping* _____
5. Continence _____	*5. Managing Medications* _____
6. Toileting _____	*6. Using Transportation* _____
7. Falling _____	*7. Paying Bills/Managing Money* _____
	8. Using Telephone _____
Would you like to speak with a nutritionist? Yes / No *If yes, best time to reach you & phone number ?* _____	
Staff: _____	*Date:* _____