

CLIENT REFERRAL FORM
Open Arms of Minnesota

1414 East Franklin Avenue, Minneapolis, MN 55404

Phone (612) 872-1152

Fax (612) 872-0866

Client Name: First _____ Middle Initial _____ Last _____

Address _____ Apt. # _____

City _____ Zip Code _____ County _____

Home Phone _____ Second Phone _____ Date of Birth _____

Reason for Meals: *Check all that apply*

HIV/AIDS A.L.S M.S. Cancer type _____

_____ Chemotherapy: dates _____

Other chronic/progressive illness _____ Radiation: dates _____

_____ Surgery: date _____

Please estimate how long meals might be needed _____

Referral Source: I verify this client's diagnosis. _____ (please initial) Date: _____

Name: _____ Signature: _____

Title: _____ Organization: _____

Email: _____ Telephone: _____

I have a current release of information on file for this client. No Yes: *Effective until* _____

Additional Contact: County Worker Case Manager Medical Professional *Other* _____

Name: _____ Organization: _____

Email: _____ Telephone: _____

Additional Contact: County Worker Case Manager Medical Professional *Other* _____

Name: _____ Organization: _____

Email: _____ Telephone: _____

Nutrition Information:

Height _____ Weight _____ Date Taken _____

How has client's weight changed in the last 6 months?

Gained _____ pounds *Was it planned?* _____

Lost _____ pounds *Was it planned?* _____

_____ Client weight has remained about the same.

Please check any nutrition difficulties for the client:

Nausea / Vomiting

Swallowing problems

Chewing problems

Constipation

Diarrhea

Taste changes

Date of last medical appointment _____

Client Name: _____

Demographic Information:

You will still qualify for our service if you choose not to answer.

Living Situation:

- Homeless on Street
Institution
Permanent Housing
Non-Permanent Housing
Unknown
Refused
Other

Insurance:

- Private
Medicare
Medicaid / MA
Other Public
MCHA
No Insurance
Unknown
Refused
Other

Race:

- American Indian
Caucasian
African American/Black
African Born
Pacific Islander or Asian
Hispanic/Latino
Unknown
Refused
Other

Ethnicity:

- Hispanic
Not Hispanic
Unknown
Refused

Gender:

- Male
Female
M to F Transgender
F to M Transgender

Country of Client's Birth: U.S.A. Unknown Other (please identify)

Anticipated Annual Family Income: \$ per year or \$ per month.

Number of people legally dependent on income, including client:

Number of children living with client 20+ hours per week:

Extra meals requested for dependents or caregivers? Please explain.

Is it possible that client is eligible for reimbursement for meals through CADI or elderly waivers? No Yes Unknown

HIV Specific:

We need the following information from HIV+ clients as a requirement of a federal grant. The information is reported anonymously twice a year. We will ask for proof of income on an ongoing basis.

A. I'm attaching proof of income.

- Recent Pay Stub Benefit Statement
Recent Tax Return Affidavit/ Letter of support

or

B. Client cannot provide proof of income.

Reason

Diagnosis:

- HIV+, no AIDS diagnosis
HIV+, AIDS diagnosis
HIV+, AIDS diagnosis unknown
Client does not have HIV/AIDS

Year of Diagnosis

Year diagnosed HIV+
If applicable, year of AIDS diagnosis

Exposure:

- Male to Male Sex Injecting Drug Use
Male/Female Sex Hemophilia
Blood Recipient Unknown
Perinatal Transmission Refused
Other

OPEN ARMS Evaluation Form INTAKE

<p>Date _____</p> <p>Name _____</p> <p>Phone # _____</p> <p>Breast cancer clients only: Which treatments are you currently undergoing? (check all that apply) <input type="checkbox"/> Chemotherapy Start: _____ End: _____ <input type="checkbox"/> Radiation Start: _____ End: _____ <input type="checkbox"/> Surgery Date _____</p> <p>HIV+ clients only: What year were you first diagnosed? HIV+ _____ Do you have an AIDS Diagnosis? Y N If yes, from what year: _____</p>	<p>Weight _____</p> <p>Height _____</p> <p>How has your weight changed in the last 6 months? Gained # of pounds _____ Lost # of pounds _____ Weight is about the same _____ This was <input type="checkbox"/> planned <input type="checkbox"/> unplanned</p> <p>Clinic / Nurse / Casemanager: _____ _____</p> <p>Date of last medical appt. ___/___/___</p>	<p>How is your appetite? <input type="checkbox"/> Poor <input type="checkbox"/> Fair <input type="checkbox"/> Good <input type="checkbox"/> Varies</p> <p>Nutrition difficulties: <input type="checkbox"/> Nausea/ Vomiting <input type="checkbox"/> Constipation <input type="checkbox"/> Swallowing Problems <input type="checkbox"/> Diarrhea <input type="checkbox"/> Chewing Problems <input type="checkbox"/> Taste Changes</p> <p>Do you have any special diet needs? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please explain: _____ _____ _____</p>
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For each of the following statements, please check the box that comes closest to the way you felt in the past month.	All of the time 1	Most of the time 2	Some of the time 3	Little of the time 4	None of the time 5	DOES NOT APPLY 6
I eat three meals a day.	1	2	3	4	5	6
I eat nutritious and balanced meals.	1	2	3	4	5	6
I am able to keep a healthy weight, or I am progressing toward a healthy weight.	1	2	3	4	5	6
I am able to manage the side effects of my medications and/or treatment.	1	2	3	4	5	6
I am able to keep my medical appointments.	1	2	3	4	5	6
I have the financial resources to eat nutritious and balanced meals.	1	2	3	4	5	6
I am able to accomplish daily activities.	1	2	3	4	5	6
Grocery shopping and meal preparation are easy for me / not stressful.	1	2	3	4	5	6
I don't feel isolated. I have enough contact with and support from others.	1	2	3	4	5	6
I am satisfied with my energy level.	1	2	3	4	5	6

Comments: _____
