

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: _____

Client Consent to Release Information:

I understand that any information about me provided to Open Arms of Minnesota is confidential and will not be disclosed without my consent in this release.

I authorize my health care provider or social worker listed below to verify my health information for Open Arms of Minnesota and share information about me that is relevant to this service.

I also agree that staff of Open Arms of Minnesota may contact individuals I supply as additional contacts if needed to provide meal service, or in emergency situations.

I understand that my information will be reported anonymously to funding sources

This release will remain in effect for a year from the date below unless revoked in writing, or I am no longer a client of Open Arms of Minnesota.

Client Signature

Date

Client Name (please print)

Name of medical professional, social worker or other contact:

Name: _____

Organization: _____

Phone: _____

Name: _____

Organization: _____

Phone: _____

Name: _____

Organization: _____

Phone: _____