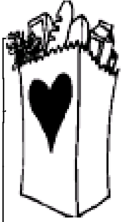
(Breast Cancer)

(For office use only)



FOOD & FRIENDS®

Date received: ____________

Client Intake Form

Name: ____________
(First) (Middle Initial) (Last)

Address: ____________
(Street) (Complex name)

____
(Apartment #) (City) (State) (Zip Code)

• **Client lives:** ☐ Alone ☐ w/ Partner ☐ w Family/Friends ☐ In a Rooming House/Group Home

Phone: (____) ____ - ______ *Client Prefers to Speak:* ____________

• **Will someone be home between 10:00a.m. & 3:00 p.m. to receive the meal?** ☐ Yes ☐ No

Begin Date: ____ / ____ / ____

Demographic Information:

Sex: ☐ Female ☐ Male ☐ Transgendered

Race: ☐ African American
☐ White
☐ Hispanic/Latina (-o)
☐ Native American
☐ Asian/Pacific Islander
☐ Other ____________

Date of Birth: ____________

Total Monthly Income:

Receives Public Assistance? (SSI, SSDI, GPA, TANF)

☐ Yes ☐ No

Total Monthly Household income $________

Does the client receive other food entitlements?

☐ Yes ☐ No If yes, list____________

Any Dependents? (Must be age three or older)

_______ total # dependents _______ # on service

Dependent Delivery Schedule:

☐ HDM ☐ GTG

Dep. Name ____________ D.O.B._______
Dep. Name ____________ D.O.B._______
Dep. Name ____________ D.O.B._______

General Medical Insurance Status:

☐ (Multiple answers permitted)
☐ Private Insurance / HMO
☐ Medicaid
☐ Medicare
☐ Medicaid Waiver
☐ Uninsured
☐ Unknown
☐ Other Public Insurance

FOOD & FRIENDS SERVICE ELIGIBILTY

Client must have a primary life-challenging or life-limiting illness that demonstrates a nutritional need and is indicated by inadequate food intake and treatment protocol:

Please check at least one box in each of the three categories
Clients will be re-certified on a bi-yearly basis

1.*Primary Illness*

- ☐ Breast Cancer
- ☐ Other Cancer

____

- ☐ Other Illness

____

- ☐ Symptoms/Other Health Problems

____

2.Compromised Nutritional Status

Inadequate Food Intake due to:

- ☐ Chewing/swallowing difficulties
- ☐ Lack of appetite
- ☐ Diarrhea
- ☐ Nausea/vomiting
- ☐ Inability to prepare/procure food
- ☐ Wasting

3.*Currently managing side effects and*

- ☐ Chemotherapy
- ☐ Radiation
- ☐ Hormone therapy
- ☐ Immunotherapy
- ☐ Palliative therapy
- ☐ Patient currently in hospice
- ☐ Patient no longer receiving treatment

Reason _______________

____

Medications

____

____

____

____

Medical Information:

Other health problems (not listed on eligibility form):

____

Previous Hospitalizations (starting with most recent):

Height:______ **Current weight:**______ **Usual weight:**______ **BMI**______

Weight loss? ☐ **Yes** ☐ **No Amount:** ______ **Length of time:** ______ **When** ______

Weight information reported by: ______________________________

Date (mo./yr.)	Hospital	Reason(s)
______		
______		

ACTIVITES OF DAILY LIVING (ADL) ***(please check all that apply)***

The Client is…

- ☐ **Able to perform all ADL,** especially providing or preparing one's daily meals, *i.e. needs no help*
- ☐ **Able to perform limited amounts of ADL,** especially providing or preparing one's daily meals, *i.e. needs very little help*
- ☐ **Physically unable to perform limited amounts of ADL**, especially providing or preparing one's daily meals, *i.e. needs some help*
- ☐ **Physically unable to perform all ADL,** especially providing or preparing one's daily meals, *i.e. needs help at all times*

Client *Delivery Schedule:*

☐ **HDM** ☐ **GTG**

Diet Type:

- ☐ Regular
- ☐ Vegetarian
- ☐ Child
- ☐ No Red Meat (GTG Only)
- ☐ No Dairy
- ☐ No Fish
- ☐ Homeless
- ☐ Low Fat
- ☐ Pureed
- ☐ Diabetic
- ☐ Soft
- ☐ Mild (Renal/Bland

Supplement: *(For internal use only)*

Ensure (Non-dairy) Delivery day(s)______ Glucerna (diabetic) Delivery day(s) ______

Nepro (Renal) Delivery day(s) ______

Contact Information:

Referral Source:	*Case Manager/Social Worker:*
Name:	Name:
Organization:	Organization:
Phone:	Phone:
Email:	Email:

Physician:

Name: **Affiliation:**

Phone: **Last appointment:**

Psychosocial information:

Emergency Contact:

Name: **Relationship:**

Day Phone: **Eve. Phone:**

I, the undersigned, do attest that my client (client name), ,
meets Food & Friends eligibility requirements.

Referral agent or doctor (Printed) **Title** **Agency**

Signature (of referral agent or doctor) **Phone** **Date**

Please Mail or Fax this form to:
Client Services
Food & Friends
219 Riggs Road, NE Washington, DC 20011
Phone: (202) 269-6825 Fax: (202) 635-4261