



Nutrition Referral for Home Delivered Meals

Emergency Need:

This form must be completed and forwarded to the appropriate Home Delivered Meal nutrition provider agency.

Currently receiving home delivered meals from another source: Yes No
 Days Older Adult to receive meals (circle all that apply): M T W R F All M-F Weekend 2nd Meals
 Type of meal(s): Hot Cold Frozen
 Special Notes:

Older Adult Demographic Information

Name:		Authorized Rep:	
Address:		DOB:	Phone:
			Rep:
Ethnicity: Hispanic or Latino Race: White Non Hispanic White Hispanic American Indian or Alaskan Native Asian	Not Hispanic or Latino African American Native Hawaiian or Pacific Islander Other Race Two or More Races	Marital Status: M ___ D ___ S ___ W ___ Legally Separated ___ Domestic Partner ___	Gender: M ___ F ___ Other _____
Limited English Speaking: Yes No If yes, primary language spoken:	Below Poverty: Yes No Monthly Income:	Lives Alone: Yes No Type of Housing: Home Apt Subsidized Housing: Yes No	

Nutrition Risk Screen (circle points under Yes or No)

	Y	N		Y	N
I have an illness or condition that has made me change the kind or amount of food I eat.	2	0	I eat alone most of the time.	1	0
I eat less than two meals a day.	3	0	I take three or more different prescribed or over-the-counter drugs a day.	1	0
I eat few fruits and vegetables, or milk products.	2	0			
I have three or more drinks of beer, liquor or wine almost every day.	2	0	Without wanting to, I have lost or gained ten pounds in the last six months.	2	0
I have tooth or mouth problems that make it hard for me to eat.	2	0	I am not always physically able to shop, cook and/or feed myself.	2	0
I don't always have enough money to buy the food I need.	4	0			
Totals			Totals		

Six or more points = high nutritional risk Combined column totals: _____/21 possible points

Impairment/Problem with Activity of Daily Living 0 No Assist = No; 1-3 Assist = Yes; 4 Unknown = No	Pts	Y/N	Impairment/Problem with Instrumental Activities of Daily Living 0 No Assist = No; 1-3 Assist = Yes; 4 Unknown = No	Pts	Y/N
Eating			Laundry		
Bathing			Shopping		
Grooming			Light Housework		
Dressing			Heavy Housework		
Toileting			Telephone		
Walking/Mobility			Financial Management		
Transferring (in/out of bed/chair)			Transportation		
			Meal Preparation		
			Medication		
Total Points			Totals Points		
Total "Yes" = _____ Total "No" = _____			Total "Yes" = _____ Total "No" = _____		

Major Health Problems (circle all that apply)					
Ambulation: Full Partial Assisted Bedfast				Other major health concerns (describe):	
Vision: Full Limited Glasses Blind					
Hearing: Full Hard of Hearing Hearing Aid Deaf				Determination of Need (DON) score:	
Additional Nutrition Information					
Who does the grocery shopping? How often?			Can Older Adult feed self? Yes No If no, who assists? What type of help: Cutting Puree Feeding		
Is anyone available to prepare food? Yes No If yes, who? What days? Which meals?			Does Older Adult have any of these difficulties with: (circle all that apply) Swallowing Indigestion Heartburn Vomiting Diarrhea Constipation		
Usually how much of each meal does the Older Adult eat? (circle one) Under 25% 25% 50% 75% Over 75%			How is the Older Adult's appetite in general? (circle one) Poor Fair Good Excellent		
Older Adult's kitchen facilities/equipment: (circle all that apply) Kitchen Kitchen privileges Stove Microwave Refrigerator Freezer w/available space			Is Older Adult able to use these appliances unsupervised: (circle all that apply) Stove Microwave Refrigerator Freezer		
Older Adult food source for the weekends:			Special Diet Needs: General Diabetic		
Condition of the home: Good Poor If poor, specify:			Dietary restrictions:		
Reason for Home Delivered Meals: (circle all that apply)			Food allergies:		
<ul style="list-style-type: none"> • Homebound • Permanently disabled • Temporarily disabled • Respite for caregiver • Meal for spouse or disabled adult in home • Other (specify) _____ 					
Older Adult will benefit from Home Delivered Meals because: (circle all that apply)					
<ul style="list-style-type: none"> • Meals will increase nutritional intake as Older Adult has a limited income • Older Adult has difficulty cooking, tires easily • Older Adult is recovering from surgery, illness, etc. • Other (specify): _____ 					
Duration of meals: (circle one) Short term Long term					
Other Contacts Information					
Physician Name:			Physician Phone:		
Emergency Contact Name:			Home phone:		Cell phone:
Address:					
Emergency Contact Name:			Home phone:		Cell phone:
Address:					
<u>Authorization of Release of Information</u>					
I give permission to _____ to send a copy of this assessment form to the Home Delivered Meal Provider, _____, and to discuss my needs with the Provider and/or the AAA.					
Older Adult Signature:				Date:	
I certify this Older Adult meets eligibility criteria for Home Delivered Meals under the Older Americans Act.					
Signature:			Phone:		
Case Manager Name:			Email:		
Organization:			Date:		
HDM Start Date:		Reassessment Date:		Termination Date:	
Driver instructions: (circle all that apply) Ring bell Knock loudly Beware of dog(s) Other: _____					