



Nutrition Referral for Home Delivered Meals

Emergency
Need:
Yes No

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 (check 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: _____ City: _____
 State: _____ Phone Number: _____ Rep Phone Number: _____
 Date of Birth: _____ Gender: Male Female Other
 Marital Status: Married Divorced Single Widowed Legally Separated Domestic Partner
 Ethnicity: Hispanic or Latino Not Hispanic or Latino
 Race: White Non-Hispanic African American
 White Hispanic Native Hawaiian or Pacific Islander
 American Indian or Alaskan Native Other Race
 Asian Two or More Races
 Limited English Speaking: Yes No Below Poverty Line: Yes No
 If yes, primary language spoken: _____ Monthly Income: _____
 Type of Housing: Home Apartment Subsidized Housing: Yes No Lives Alone: Yes No

Nutrition Risk Screen (check 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.			I don't always have enough money to buy the food I need.		
I eat less than two meals a day.			I eat alone most of the time.		
I eat few fruits and vegetables, or milk products.			I take three or more different prescribed or over-the-counter drugs a day.		
I have three or more drinks of beer, liquor or wine almost every day.			Without wanting to, I have lost or gained ten pounds in the last six months.		
I have tooth or mouth problems that make it hard for me to eat.			I am not always physically able to shop, cook, and/or feed myself.		

Six or more points = High nutritional risk

COMBINED TOTALS: ___ /21 possible

Impairment/Problem with Activity of Daily Living			Impairment/Problem with Instrumental Activities of Daily Living		
0 – no assist; 1 – min; 2 – mod; 3 – max; 4 – unknown	Pts	Y/N	0 – no assist; 1 – min; 2 – mod; 3 – max; 4 – unknown	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		
Totals			Totals		
Total "Yes": ___ / Total "No": ___			Total "Yes": ___ / Total "No": ___		

Major Health Problems (check 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?			Can Older Adult feed self? Yes No		
How often:			If no, who assists? _____		
			What type of help: Cutting Puree Feeding		
Is anyone available to prepare food? Yes No			Does Older Adult have any of these difficulties with: (check all that apply)		
If yes, who? _____		What days? _____	Which meals? _____		Swallowing
					Indigestion
					Heartburn
					Vomiting
					Diarrhea
					Constipation
Usually how much of each meal does the Older Adult eat? (check one)			How is the Older Adult's appetite in general? (check one)		
Under 25% 25% 50% 75% Over 75%			Poor Fair Good Excellent		
Older Adult's kitchen facilities/equipment: (check all that apply)			Is Older Adult able to use these appliances unsupervised? (check all that apply)		
Kitchen		Kitchen privileges		Stove	
Stove		Microwave		Refrigerator	
Refrigerator		Freezer /available space		Freezer	
Older Adult food source for the weekends:			Special Diet Needs: General Diabetic		
Condition of the home: Good Poor			Dietary restrictions:		
If poor, specify: _____			Food allergies:		
Reason for Home Delivered Meals: (check all that apply)					
Homebound			Respite for caregiver		
Permanently disabled			Meal for spouse or disabled adult in home		
Temporarily disabled			Other (specify) _____		
Older Adult will benefit from Home Delivered Meals because: (check all that apply)					
Meals will increase nutritional intake as Older Adult has limited income			Older Adult is recovering from surgery, illness, etc.		
Older Adult has difficulty cooking, tires easily			Other (specify) _____		
Duration of meals: (check one)			Short term Long term		
Other Contacts Information					
Physician Name:			Physician Phone:		
Emergency Contact Name:			Home Phone:		Cell Phone:
Address:			City:		State:
Emergency Contact Name:			Home Phone:		Cell Phone:
Address:			City:		State:
AUTHORIZATION OF RELEASE OF INFORMATION					
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>I certify that this participant meets eligibility criteria for Home Delivered Meals under the Older Americans Act.</i>					
Case Manager Name:			Phone:		
Organization:			Email:		
Signature:			Date:		
HDM start date:		Reassessment date:		Termination date:	
Driver Instructions: (check all that apply) Ring bell Knock loudly Beware of dog(s) Other _____					