

## Meals on Wheels Referral Form

Completed forms are to be posted to 11-13 Darley Street, Newtown 2042 or faxed to 9550 6832.  
Phone: (02) 9335 2153

### Client Details:

Date of referral:	
Last name:	Title: Miss Ms Mrs Mr
First name:	Gender: Date of Birth:
Address:	
Accommodation: Owned home <input type="checkbox"/> Private Rental <input type="checkbox"/> Public Rental <input type="checkbox"/> <input type="checkbox"/> Other _____	
Living: Alone <input type="checkbox"/> Partner only <input type="checkbox"/> Relatives/Other persons <input type="checkbox"/>	
Phone no/s:	Nearest Cross Street:
Country of Birth:	Pension: Age <input type="checkbox"/> DVA <input type="checkbox"/> Disability <input type="checkbox"/> N/A <input type="checkbox"/>
Ethnicity:	Language spoken at home:
Does the client identify themselves as an indigenous person? Yes <input type="checkbox"/> No <input type="checkbox"/>	
Have you ever received Meals on Wheels before? Yes <input type="checkbox"/> No <input type="checkbox"/> Detail:	
Why is assistance needed with meals?	
Is the client receiving other assistance? e.g. Home Care, CACP, Compack	
Who is providing this service?	How often do they assist the client?

### Eligibility:

Does the person have impaired functional ability? Yes <input type="checkbox"/> No <input type="checkbox"/> If so, in what areas:	
Self care <input type="checkbox"/>	Mobility <input type="checkbox"/> Domestic tasks <input type="checkbox"/> Shopping/Cooking <input type="checkbox"/>
Does the person have a disability? Yes <input type="checkbox"/> No <input type="checkbox"/> Disability:	
Is the person a carer? Yes <input type="checkbox"/> No <input type="checkbox"/>	Does the person have a carer? Yes <input type="checkbox"/> No <input type="checkbox"/>
<b>Does the person fulfil HACC eligibility criteria &amp; live in the appropriate LGA? Yes <input type="checkbox"/> No <input type="checkbox"/></b>	

### Referred by:

Self or Name:	Relationship to client:
Organisation:	Address:
Phone no/s:	
Has consent been given by the client for the referral? Yes <input type="checkbox"/> No <input type="checkbox"/>	
Client information and referral record (CIARR) attached: Yes <input type="checkbox"/> No <input type="checkbox"/>	
How did you hear about Meals on Wheels?	

**Next of kin or nominated contact:**

Next of kin/nominated contact person:  
 Relationship: Phone no/s:  
 Address: Postcode:  
 Does the person have an advocate or legal guardian? Yes  No   
 Name: Phone no/s:

**Delivery details:**

Any other special delivery details and/or safety issues: (Note - for food safety reasons meals cannot be left outside a client's home. The client or a nominated person must be available to receive the meal. If not, the meal will be returned to TFCC.)

Any relevant disability or dysfunction that would impact on the client being able to answer the door to receive the meal? e.g. mobility, hearing difficulties:

Is the residence a boarding house? Yes  No

If there are any animals are they fenced in or can they be tied up? Yes  No  N/A

Is there a history of challenging behaviour? Not known  No  Yes  provide details

**Meal requirements:**

No. of meals \_\_\_ sandwich \_\_\_ dessert \_\_\_ juice \_\_\_ required per week

Total cost per week \$ \_\_\_\_\_ Can the client afford to pay this? \_\_\_\_\_

Type of meal: Frozen  Chilled  Hot - to be eaten immediately   
 (for food safety reasons the delivery of hot meals is only recommended for clients who are unable to heat their own meals.)

To be delivered on: Mon  Tues  Wed  Thurs  Fri

If more than one meal to be delivered per day please specify:

Preferred start date: \_\_\_\_\_ Meals required for how long? \_\_\_\_\_

**Payment method:** invoices are issued on a fortnightly basis in arrears

Meals to be paid by: Cheque  Money Order  Eftpos  Cash  Credit card  payment  
 (except American Express and Diners Club) to Council's Citizens Service Centre - 2 Fisher St, Petersham or Tom Foster at 11-13 Darley Street, Newtown

By whom: Phone no/s:

**Special diets:**

It may be possible to cater for individual's special dietary needs. If a special diet is required for any medical, cultural or religious reasons please indicate what type of diet this is:

Puree  Minced/Mashed  Easy Chew  Bland  Diabetic  Vegetarian  Low Fat

Other  please specify

Food allergies:

**Office Use Only:**

Referral completed by:

Date:

General comments: