



Nutrition Referral for Home Delivered Meals

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 2 nd 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 Microwave Refrigerator Freezer		
Stove Microwave					
Refrigerator Freezer /available space					
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 _____					