Mama's Kitchen Client Referral Form

PLEASE NOTE: Read eligibility criteria on website before submitting. All highlighted fields are required for processing. Due to the high volume of clients we serve, **incomplete forms** with **missing information will not be reviewed**.

CLIENT INFORMATION

MEMBER CONSENTED TO REFERRAL ☐ Yes ☐ No

NAME (LAST, FIRST): ______________________ DATE OF BIRTH: ______________________

GENDER: ☐ Male ☐ Female ☐ Transgender ☐ Nonbinary LANGUAGE: ☐ ENG ☐ SPA ☐Other: __________

PHONE NUMBER: ________________ CAN RECEIVE TEXTS? ☐ Yes ☐ No EMAIL: ________________

SECONDARY CONTACT: ____________________ PHONE NUMBER: ______________________

ADDRESS: ______________________________ CITY: ____________ ZIP CODE: ________

MEDI-CAL: ☐ Yes ☐ No | IF YES, PLEASE PROVIDE MEDI-CAL NUMBER - CIN # ______________________

PRIMARY CARE PROVIDER (PCP) NAME: ______________________________________

PCP PHONE: ________________ PCP FAX: ________________ PCP EMAIL: ________________

ELIGIBILITY CRITERIA- QUALIFYING DIAGNOSES

(CLIENT ONLY NEEDS TO QUALIFY WITH ONE DIAGNOSIS, BUT PLEASE CHECK OFF ALL DIAGNOSES THAT CLIENT HAS.)

☐ AIDS HIV	ICD 10 CODE:	
☐ CANCER	TYPE:	ICD 10 CODE:
☐ CONGESTIVE HEART FAILURE (CHF) Last Hospitalization related to CHF Discharge Date*:	TYPE:	ICD 10 CODE:
☐ DIABETES TYPE 2 ICD 10 CODE:	HBA1C LEVEL:	LAB DATE**:
☐ CHRONIC KIDNEY DISEASE ☐ N18.3 - STAGE 3 ☐ N18.4 - STAGE 4 ☐ N18.5 - STAGE 5 (no dialysis) ☐ N18.6 - ESRD (dialysis)	PLEASE INCLUDE LABS LAB DATE: A1C (if applicable): LAB DATE: K+: PHOS: GFR:	IF ON DIALYSIS PROVIDE START DATE***: TYPE: ☐ HD ☐ PD ****Only patients that have **started dialysis** within the last 12 months will be accepted.*

** Must have had* ***hospitalization related to CHF*** within the last 12 months to be accepted.

Only A1C lab results that are* ***8% or higher *and within the last 3 months will be accepted.*

NAME (LAST, FIRST): ______________________ DOB:____________________

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MEDICAL NECESSITY

To qualify, program participants must have one or more of the following medical necessities *(select all that apply)*:

☐ Peripheral neuropathy, significantly limiting standing or ambulation
☐ Fatigue or pain that significantly limits ability to prepare food
☐ Unintentional weight loss of more than 5% of baseline
☐ Severe diarrhea, nausea, or vomiting
☐ Bedbound or other mobility issues
☐ Anxiety, depression, or other mental health issues
☐ Mild to severe shortness of breath

DIET HISTORY

1. If applicable, please list any dietary restrictions/*preferences: ______________________________________
   ☐ DASH/Diabetic
   ☐ Renal (Low K+, Low Phos)
   ☐ Low K+
   * Please note we may not be able to accommodate all preferences

2. Do you have any food allergies/intolerances?
   ☐ Yes
   ☐ No
   ☐ Unsure
   a. * If yes, please list all allergies: ____
   * Please note we **do not** serve anyone with a **severe anaphylactic allergy** (with the exception of shellfish only as we will never serve this type of fish here).

Please fill out these Nutrition Questions so we can better assess the nutritional needs of the client. For those who need more support, our Registered Dietitians may give them a call and/or enroll them in our **12-week Intensive Nutrition Program** where they will receive over-the-phone **Medical Nutrition Therapy** once a month.

NUTRITION ASSESSMENT- MALNUTRITION SCREENING TOOL (MST)

1. Have you recently lost weight *without trying*?
   ☐ No (0)
   ☐ Unsure (2)
   ☐ Yes (see below)

   a. If yes, how much weight have you lost?
   ☐ 2-13 lb (1)
   ☐ 14-23 lb (2)
   ☐ 24-33 lb (3)
   ☐ 34 lb or more (4)
   ☐ Unsure (2)

Weight loss score: _______

2. Have you been eating poorly because of a decreased appetite?
   ☐ No (0)
   ☐ Yes (1)

Appetite score: _______

3. Add weight loss and appetite scores to find MST score

MST Score: ☐

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ANTHROPOMETRIC/HEALTH ASSESSMENT

Height in feet: _____ Height in inches: ______

Current weight (lbs): ____________

Usual Body Weight (lbs): ____________

If available:

Cholesterol: ____________

HDL: ____________

LDL: ____________

Triglycerides: ____________

Activity level:

- ☐ Sedentary
- ☐ Lightly Active
- ☐ Moderately Active
- ☐ Very Active
- ☐ Extremely Active
- ☐ Unknown

Other health diagnoses: ____

REFERRAL VERIFICATION | SUBMISSION | RELEASE OF INFORMATION

A signature certifies that the information on this document is accurate and that the referred party agrees to the release of information obtained herein and to be contacted for program participation. Completed applications can be emailed to secure@mamaskitchen.org or faxed to 619.233.6283.

PROVIDER SIGNATURE: ________________________________ **DATE:** ____________________
(MD, NP, PA, RD, RN OR LCSW ONLY)

PRINT NAME: ____________________________ **TITLE:** ____________________________

AGENCY / CLINIC / HOSPITAL NAME: ____

EMAIL: ___________________________ **PHONE:** _______________ **FAX:** _____________

CASE MANAGER / SOCIAL WORKER

NAME: ________________________ **AGENCY:** ___________________________________

EMAIL: ___________________________ **PHONE:** _________________ **FAX:** ___________

IF THE INDIVIDUAL THAT REFERRED THIS CLIENT DOES NOT HAVE ANY OF THE FOLLOWING TITLES: MD, NP, PA, RD, RN OR LCSW PLEASE PROVIDE LETTER OF DIAGNOSIS