

Medically Tailored Meals/Nutritional Counseling Referral Form

Referral Date: _____ Hospital/NF Discharge Date: _____

Referral Information:			
Support Coordination Agency:			
Support Coordinator (SC):			
SC Phone:		SC Email:	
Participant Information:			
Name:		DOB:	Last 4 of SSN:
Street Address:		Apt/Unit:	
City:		State:	Zip Code:
Secondary Contact Name:			Phone:
Relationship to Participant:			Email:
Nutritional Counseling: (No more than 3 sessions per 12-week MTM period)			
<input type="checkbox"/> Yes	<input type="checkbox"/> No	If yes: <input type="checkbox"/> 1 Session <input type="checkbox"/> 2 Sessions <input type="checkbox"/> 3 Sessions	
Medically Tailored Meals (MTMs) – Meal Plan Selection:			
# of Meals per Week:	X	Weeks: 12	Start Date: _____
End Date: _____			
Desired Menu Type:			
<input type="checkbox"/> Lower Sodium	<input type="checkbox"/> Heart Friendly	<input type="checkbox"/> Vegetarian	<input type="checkbox"/> Pureed
<input type="checkbox"/> Renal-Friendly	<input type="checkbox"/> Gluten Free	<input type="checkbox"/> Diabetes Friendly	
Diagnosis:			
<input type="checkbox"/> Congestive Heart Failure (150.9)		<input type="checkbox"/> Diabetes (E11.8)	<input type="checkbox"/> Gluten Intolerance (K90.4)
<input type="checkbox"/> Oral Dysphagia (R1311)		<input type="checkbox"/> Renal Disease (N18.9)	
Allergens: (NOTE: If the allergen is contained anywhere in the meal kit, the meal will not be available to the participant.)			
<input type="checkbox"/> Milk <input type="checkbox"/> Fish <input type="checkbox"/> Shellfish <input type="checkbox"/> Tree Nuts <input type="checkbox"/> Sesame <input type="checkbox"/> Egg <input type="checkbox"/> Peanut <input type="checkbox"/> Soy <input type="checkbox"/> Wheat <input type="checkbox"/> Unknown <input type="checkbox"/> Other: _____ <input type="checkbox"/> No Known Food Allergies			
Allergens/Food Preferences/Special Delivery Instructions:			
MTM Staff Completes the Following:			
<input type="checkbox"/> Menu Selection confirmed appropriate for specific health condition(s). <input type="checkbox"/> Allergen types confirmed. <input type="checkbox"/> No known food allergies.			