



Referral Instructions

- All referral sources must fill out **General Information** and **Health Information**, obtain **(2) client signatures (Release of Medical Information & Client Agreement)**, and fill out **Provider Information**.
- All corresponding sections for **applicable diagnoses** must also be completed.
- We cannot accept progress notes
- **SERVICES CANNOT BE STARTED WITHOUT ALL REQUIRED INFORMATION AND SIGNATURES.**

SERVICE ELIGIBILITY

MANNA provides temporary, medically tailored meals for individuals with a serious illness AND an acute nutritional risk. Please read the criteria below to determine if your patient may be eligible for MANNA's services. Once all information is completed and returned, MANNA's Nutrition & Client Services Department will determine final eligibility. We will contact you if your patient does **not** qualify for services.

Eligibility criteria:

Clients must have a diagnosis AND secondary nutritional risk factor(s).

See below for a sample of qualifying conditions

DIAGNOSES (examples)

- HIV/AIDS
- Cancer (undergoing active treatment)
- End Stage Renal Disease
- Heart Disease
- Diabetes
- Hep C or Liver Disease

SECONDARY NUTRITIONAL RISK FACTORS: (examples)

- New diagnosis with disease-related complications
- Start of medical treatment (hemodialysis, chemotherapy, radiation, wound care)
- Recent, unintentional weight loss
- Recent hospitalization (within one month and length of stay >3 days)
- Recovery from a recent surgery

COMPLETED FORMS

Mail:

MANNA Client Services
420 North 20th Street
Philadelphia, PA 19130

Fax:

(215) 496-9102
Attn: MANNA Client
Services

QUESTIONS?

Please call MANNA's Nutrition &
Client Services Department at
215-496-2662 x5

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Referral Form

MAIL OR FAX COMPLETED FORMS:

Mail:
MANNA Client Services
420 North 20th Street
Philadelphia, PA 19130

Fax:
(215) 496-9102
Attn: MANNA
Client Services

GENERAL INFORMATION *required*

Client is referred for: ☐ Nutrition Counseling ☐ Meal Delivery ☐ Both

Name First: _____ Last: _____ Date of Birth: ____/____/____

Street Address: _____ Apartment: _____

City: _____ State: _____ Zip Code: _____ Phone: (____) _____ - _____

Alt Phone: (____) _____ - _____ E-Mail Address: _____

Emergency Contact Name: _____ Emergency Contact Phone: (____) _____ - _____

Gender: ☐ Male ☐ Female ☐ Trans Female ☐ Trans Male ☐ Other: _____

Ethnicity: ☐ Hispanic ☐ Non-Hispanic

Race (please check all that apply): ☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American
☐ Native Hawaiian or Pacific Islander ☐ White ☐ Other: _____

Language: ☐ English ☐ Spanish ☐ Other: _____

HEALTH INFORMATION *required*

Please select all patient diagnoses and complete all corresponding sections.

- ☐ HIV/AIDS (Section A) ☐ Diabetes (Section B) ☐ Cancer (Section C) ☐ Kidney Disease (Section D)
☐ Cardiovascular disease (Section E) ☐ Wounds (Section F) ☐ Other: _____ (Section G)
or hypertension

Weight History

REQUIRED: Current Height: _____ Current Weight: _____ Date: ____/____/____

Weight 1 Month Ago: _____ Date: ____/____/____ OR ____ No Record

Weight 3 Months Ago: _____ Date: ____/____/____ OR ____ No Record

Weight 6 Months Ago: _____ Date: ____/____/____ OR ____ No Record

Blood Pressure: _____ Date: ____/____/____ or No Record: _____

Continued on following page

HEALTH INFORMATION *continued*

Hospitalization in the last 30 Days? ☐ **Yes** (please specify below) ☐ **No** ☐ **No Record**

Admit Date: ____/____/____ Discharge Date: ____/____/____

Reason: _____ Hospital: _____

Admit Date: ____/____/____ Discharge Date: ____/____/____

Reason: _____ Hospital: _____

Surgery in the last 30 Days? ☐ **Yes** (please specify below) ☐ **No** ☐ **No Record**

Admit Date: ____/____/____ Discharge Date: ____/____/____

Reason: _____ Hospital: _____

Admit Date: ____/____/____ Discharge Date: ____/____/____

Reason: _____ Hospital: _____

Food Allergies: _____

Please describe reaction and severity: _____

FOOD ALLERGY AGREEMENT:

MANNA is **not** an allergy-free facility, and there is a risk of cross-contamination even when the meal or food does not contain the allergen named above. I am aware that my patient has a food allergy (please see above) and, despite this allergy, I grant permission for my patient to receive MANNA's meal services.

Physician Signature: _____

(Physician Signature *required* to start MANNA services if patient has a food allergy)

CLIENT SIGNATURES *required*

Client Release of Medical Information & Privacy Notice

I, _____ authorize MANNA to release any relevant information to my care providers. This release is reciprocal, i.e., I am giving my permission for all parties identified above to communicate back and forth with one another. I understand that all information obtained by MANNA will remain confidential and will only be available to MANNA staff and volunteers as necessary for me to receive services. I am aware that I may rescind this authorization any time by notifying MANNA in writing.

Client Signature: _____ **Date:** ____/____/____

Continued on following page

CLIENT SIGNATURES *continued*

Client Agreement and Release of Liability

I understand that I am participating in the MANNA meal delivery program (the "Meal Delivery Program"), in which food prepared by MANNA will be delivered to my home by a MANNA staff member or volunteer (a "MANNA Person"). In exchange for my being allowed to participate in the Meal Delivery Program, I agree to the following:

I am aware that services from MANNA are free of charge and that it is a temporary program. MANNA's services **will not** affect eligibility for other public benefits, i.e. SNAP/food stamps.

I agree to be home between the hours of 8:00am and 5:30pm on my delivery day to get my meals. I must call at least two days ahead to cancel or change my delivery, 215-496-2662 x2.

I understand that if I miss 2 deliveries in 4 weeks or 6 deliveries in 6 months, MANNA has the right to stop and/or cancel my services.

I agree to call Client Services right away at 215-496-2662 x5 to inform them of any changes in my address or phone number.

I will treat MANNA staff and volunteers with respect and will not be improper or verbally/physically abusive to staff or volunteers. Failure to comply will result in cancellation of service.

I know that all clients must agree to follow these rules and that MANNA has the right to stop and/or cancel services at any time if I do not comply with these set rules.

I assume all risks, known and unknown, foreseeable and unforeseeable, in any way connected with or arising out of my participation in the Meal Delivery Program. I accept personal responsibility for any liability, injury, loss, or damage in any way connected with my participation in the Meal Delivery Program.

I hereby release MANNA and its affiliates, directors, employees, agents, volunteers, donors, representatives, successors, and assigns (each, a "MANNA Party"), from any and all liability for and waive any and all claims for injury, loss, or damage, including attorneys' fees, in any way connected with my participation in the Meal Delivery Program (a "Claim"). This release does not impact my ability to bring claims against MANNA or a MANNA Party for such party's gross negligence or criminal actions.

This Agreement shall be binding upon my heirs, executors and administrators, and shall inure to the benefit of MANNA and each MANNA Party.

MANNA participates with one or more secure health information organization networks, including an HIO called HealthShare Exchange of Southeastern Pennsylvania, Inc., ("HSX") which makes it possible for MANNA to share your Health Information electronically through a secure connected network.

MANNA may share or disclose your Health Information to HSX and other secure HIOs, including HIOs contracted with the Commonwealth of Pennsylvania, and even HIOs in other states.

Other health care providers, including physicians, hospitals and other health care facilities, that are also connected to the same HIO network as MANNA can access your Health Information for treatment, payment and other authorized purposes, to the extent permitted by law.

You have the right to "opt-out" or decline to participate in having MANNA share your Health Information through networked HIOs. If you choose to opt-out of data-sharing, through a verbal or written request, MANNA will no longer share your Health Information through an HIO network

Client Signature: _____

Date: ____/____/____

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PROVIDER INFORMATION *required*

Referral Source Information:

Name: _____ Organization: _____

☐ Case Manager ☐ Social Worker ☐ Registered Dietitian ☐ Doctor ☐ Nurse ☐ Other: _____

Phone: (____) _____ - _____ Fax: (____) _____ - _____ E-Mail: _____

Street Address: _____

City: _____ State: _____ Zip Code: _____

A Recertification process will occur in the first few months from the start of the client's services. Will you be the provider that continues to follow this client? ☐ Yes ☐ No

If not, who will follow this client? _____

Referral Signature: _____ Date: ____/____/____

Medical Care Provider(s) Information: *if different from referral source*

Provider 1

Name: _____ Organization: _____

☐ Case Manager ☐ Social Worker ☐ Registered Dietitian ☐ Doctor ☐ Nurse ☐ Other: _____

Phone: (____) _____ - _____ Fax: (____) _____ - _____ E-Mail: _____

Provider 2

Name: _____ Organization: _____

☐ Case Manager ☐ Social Worker ☐ Registered Dietitian ☐ Doctor ☐ Nurse ☐ Other: _____

Phone: (____) _____ - _____ Fax: (____) _____ - _____ E-Mail: _____

Continue to all sections that correspond with client's disease state(s)

SECTION A: HIV/AIDS

For Clients diagnosed with HIV/AIDS, a copy of their **Ryan White Eligibility Form** or the following **must be provided** with the Referral Form or services cannot be started.

- Proof of HIV/AIDS status
- Picture Identification
- Proof of Address
- Proof of Income
- Proof of Medical Insurance

Date of HIV+ Diagnosis: ____/____/____

Date of AIDS Diagnosis: ____/____/____

Mode of Transmission: _____

Active Opportunistic Infections (please specify or write "none"): _____

Hepatitis C Positive? ____ Yes ____ No ____ Unknown

Recent Lab Values: Please provide values and dates below or mark "No Record."

Lab	Value	Date	No Record
CD4 COUNT			
VIRAL LOAD			

SECTION B: DIABETES

Date of Diagnosis: ____/____/____ ____ Type 1 ____ Type 2 ____ Other: _____

Recent Lab Values: Please provide values and dates below or mark "No Record."

Lab	Value	Date	No Record
Hemoglobin A1c(%)			

Current Medications:

____ **Biguanides** e.g. Metformin (glucophage)

____ **DPP-4 inhibitors** e.g. alogliptin, linagliptin, saxagliptin, sitagliptin

____ **Insulin** (Please describe regimen: _____)

____ **Meglitinides** e.g. nateglinide, repaglinide

____ **SGLT2 Inhibitors** e.g. canagliflozin, dapagliflozin, empagliflozin

____ **Sulfonylureas** e.g. glimepiride, glipizide, glyburide

____ **Thiazolidinediones** e.g. rosiglitazone, pioglitazone

____ **Other** (please specify): _____

SECTION C: CANCER

Date of Diagnosis: ____/____/____

Metastatic? ____ Yes ____ No

Primary Site (Select One):

____ Bladder	____ Kaposi's Sarcoma	____ Pharyngeal
____ Bone	____ Laryngeal	____ Prostate
____ Brain	____ Leukemia	____ Renal
____ Breast	____ Liver	____ Salivary Gland
____ Cardiac	____ Lung	____ Skin
____ Cervical	____ Lymphoma (Non-Hodgkin's)	____ Sarcoma
____ Colorectal	____ Melanoma	____ Throat
____ Endometrial	____ Mesothelioma	____ Thyroid
____ Esophageal	____ Nasopharyngeal	____ Urethral
____ Gallbladder	____ Oral	____ Vaginal
____ Gastric	____ Ovarian	____ Other:
____ Head and Neck		_____
____ Hodgkin's Lymphoma		

Cancer Treatment (Select all that apply):

- ☐ **RADIATION:** Start date: ____ / ____ / ____
Expected end date: ____ / ____ / ____
- ☐ **CHEMOTHERAPY:**
- ☐ **INFUSION:** Start date: ____ / ____ / ____
Expected end date: ____ / ____ / ____
- ☐ **ORAL:** Start date: ____ / ____ / ____
Expected end date: ____ / ____ / ____
- ☐ **IMMUNOTHERAPY:** Start: ____ / ____ / ____
Expected end date: ____ / ____ / ____
- ☐ **SURGERY:** Date: ____ / ____ / ____
Type: _____
- ☐ **OTHER:** _____

SECTION D: KIDNEY DISEASE

Date of Diagnosis: ____/____/____ **Stage of Disease:** ____ I ____ II ____ III ____ IV ____ V

Transplant Recipient? ____ Yes (Date: ____/____/____) ____ No

Dialysis Status:

____ **Hemodialysis** ____ **Peritoneal Dialysis** ____ **Not on Dialysis**

Date of First Treatment: ____/____/____ Date of First Treatment: ____/____/____

Evidence of current edema? ____ Yes ____ No ____ No Record

Evidence of current ascites? ____ Yes ____ No ____ No Record

Recent Lab Values: Please provide values and dates below or mark "No Record."

Lab	Value	Date	No Record
GFR (mL/min/1.73 m2)			
BUN (mg/dL)			
Creatinine (mg/dL)			
Potassium (mEq/L)			
Phosphorus (mg/dL)			
Albumin (g/dL)			

SECTION E: CARDIOVASCULAR DISEASE

Active/historical cardiovascular conditions and procedures (Select all that apply):

___ **Hypertension** Date of diagnosis: ____/____/____

___ **Hyperlipidemia** Date of diagnosis: ____/____/____

___ **Heart Failure** Date of diagnosis: ____/____/____

___ **MI** Date: ____/____/____

___ **Stroke** Date: ____/____/____

___ **CABG** Date: ____/____/____

___ **PCI** Date: ____/____/____

___ **Other** (please specify): _____

Evidence of Current Edema? ___ **Yes** ___ **No** ___ **No Record**

Recent Lab Values: Please provide values and dates below or mark "No Record."

Lab	Value	Date	No Record
Total Cholesterol (mg/dL)			
LDL- C (mg/dL)			
HDL- C (mg/dL)			
Triglycerides (mg/dL)			

Current Medications (Select all that apply):

___ **Cholesterol-lowering medication(s)** e.g. statins, cholesterol absorption inhibitors

___ **Blood pressure lowering medication(s)** e.g. beta blockers, ACE inhibitors

___ **Diuretic(s)**

___ **Anti-coagulant(s)** e.g. warfarin, rivaroxaban

SECTION F: WOUND(S)

Pressure Injury? ____ Yes ____ No Date of Diagnosis: ____/____/____

Injury 1

Stage: _____

Measurement: _____

Injury 2

Stage: _____

Measurement: _____

Surgical wound? ____ Yes ____ No Date of Diagnosis: ____/____/____

Wound 1

☐ Healing ☐ Non-healing (>2 weeks)

Measurement: _____

Wound 2

☐ Healing ☐ Non-healing (>2 weeks)

Measurement: _____

Interventions

Wound Care/Pressure Relief? ____ Yes ____ No

Dietary Supplement? ____ Yes ____ No

If Yes, Type: _____ Frequency: _____

SECTION G: OTHER

Diagnosis: _____ Date of diagnosis: ____/____/____

Recent Lab Values: Please provide values and dates below.

Lab	Value	Date

Current Medications: _____

Treatment Plan: _____