Referral Instructions

- All referral sources must fill out **General Information** and **Health Information**, obtain the **client's signature** if client is present, 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

Email:
Clientservices@mannapa.org

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

Questions? *Call MANNA's Client Services Department— (215) 496-2662 ext. 5*

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Referral Form

Delivering Nourishment. Improving Health.

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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**) or hypertension ☐ Wounds (**Section F**) ☐ Other: _____ (**Section G**)

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 NOTICE:

MANNA is **not** an allergen-free facility. MANNA's meals are produced in a facility that uses milk, eggs, fish, shellfish, tree nuts, peanuts, wheat, and soybeans. Cross-contamination may occur.

CLIENT AGREEMENTS *required*

If you are NOT with the client, a MANNA staff member will contact the client to obtain all required signatures, however this will delay the start of services. You may skip this section.

If you ARE with the client, please download and print the following forms. After the client has an opportunity to review these forms, have the client sign below. Please note, we can only accept signatures directly from the client. Verbal consent is not accepted.

CLIENT AGREEMENTS & NOTICE OF PRIVACY PRACTICES
https://mannapa.org/clientagreements

Please sign and date below acknowledging receipt of and agreement with MANNA's **Client Agreement and Release of Liability** (Document 1), **Consent to Enter Home** (Document 2), and **Client Release of Medical Information & Privacy Notice** (Document 3). By signing and acknowledging receipt of said documents, you agree to be bound to the provisions thereof.

Client Name (Print): _____ **Client Signature:** _____ **Date:** _____

Continued on following page

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? _____

By signing below, you certify that all information provided on this form is true and correct to the best of your knowledge:

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

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**
Date of First Treatment: _____. _____. _____

◯ **Peritoneal Dialysis**
Date of First Treatment: _____. _____. _____

◯ **Not on Dialysis**

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)			☐

Questions? *Call MANNA's Client Services Department— (215) 496-2662 ext. 5*

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: _____

Other wound? ◯ **Yes** ◯ **No** **Date of Diagnosis:** _ _

Please describe the wound: _ _

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: _____

Questions? *Call MANNA's Client Services Department— (215) 496-2662 ext. 5*