Entregando Alimento.
Mejorando la Salud.

Información Referencial

- Todas las fuentes de referencia deben completar la **Información general** y la **Información de salud**, obtener **2 firmas del cliente** (Divulgación de información médica y Acuerdo del cliente) y completar la **Información del proveedor.**
- Se deben completar todas las secciones correspondientes para las dosis aplicables.
- No podemos aceptar notas de progreso.
- **SERVICIOS NO PUEDEN COMENZAR SIN TENER TODA LA INFORMACIÓN Y FIRMAS REQUERIDAS.**

ELEGIBILIDAD DE SERVICIO

MANNA proporciona temporalmente comidas personalizada médicamente para personas con una enfermedad grave **Y** un riesgo nutricional agudo. Lea los criterios abajo para determinar si su paciente puede ser elegible para los servicios de MANNA. Una vez que se haya completado y devuelto toda la información, el Departamento de Nutrición y Servicio al Cliente de MANNA determinará la elegibilidad final. Nos comunicaremos con usted si su paciente **no** califica para los servicios.

Criterio de elegibilidad:

Los clientes deben tener un diagnóstico **Y** un factor(es) de riesgo nutricionales secundarios. Vea abajo para una muestra de las condiciones que califican.

DIAGNÓSTICOS
(ejemplos)

- VIH / SIDA
- Cáncer (en tratamiento activo)
- Enfermedad renal en etapa terminal
- Diabetes
- Hepatitis C o enfermedad hepática

FACTORES DE RIESGO NUTRICIONAL SECUNDARIOS
(ejemplos)

- Nuevo diagnóstico con complicaciones relacionadas con la enfermedad.
- Inicio del tratamiento médico (hemodiálisis, quimioterapia, radiación, cuidado de heridas).
- Pérdida de peso reciente, no intencional
- Hospitalización reciente (dentro de un mes y estuvo hospitalizado mas de 3 días)
- Recuperación de una cirugía reciente.

FORMULARIOS COMPLETOS

Correo:

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

Fax:

(215) 496 – 9102
Attn: MANNA Client Services

¿ALGUNA PREGUNTA?

Por favor llame al departamento de nutrición y servicios al cliente – **215-496-2662 x1**

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Referral Form

Delivering Nourishment. Improving Health.

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**) 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 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:** _____ _____ _____

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? _____

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
- ☐ 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)			☐

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: _____