COMMUNITY SERVINGS
FOOD HEALS

Date: _____

Synergy Program: Medically-Tailored Groceries Referral Form

This is the referral form for the 6-month groceries program for people who are residents of Central Massachusetts, experience one or more diet-related chronic conditions (i.e. diabetes, heart disease, renal disease, etc.), and face the risk of nutritional deficiency due to food insecurity. Please complete form and submit via instructions below.

Member Information

_____

First and Last Name Date of Birth

_____

Address (Include Apartment Number)

_____

City State Zip Code

_____

Primary Phone Number Primary Language

_____

Delivery Directions *(for example: call cell phone upon arrival, doorbell is out of service)*

DIAGNOSIS (*check all that apply*)

- ❑ Coronary Artery Disease
- ❑ Congestive Heart Failure
- ❑ HIV+
- ❑ AIDS
- ❑ Hepatitis C
- ❑ Cancer
- ❑ Liver Disease
- ❑ CKD (stage): _____
- ❑ Diabetes **HgbA1c:** _____ *(if available)*
  - □ Type II □ Type I
- ❑ Renal Disease
- ❑ Lung Disease
- ❑ Multiple Sclerosis
- ❑ Parkinson's Disease

TYPE OF DIET

Choose 1:

- ❑ FB - Wellness/Diabetic/Cardiac
- ❑ FB - Vegetarian
- ❑ FB - Renal

- ❑ Food Allergies:

_____

FOOD SECURITY *(For the following questions, please respond how often the statements were true).*

1. During the month, the participant has worried that their food would run out before they got money to buy more.
   ☐ Often true ☐ Sometimes true ☐ Never true
2. During the month, the food that the participant bought just didn't last and they didn't have money to get more.
   ☐ Often true ☐ Sometimes true ☐ Never true

CAPACITY TO COOK AT HOME

The grocery recipient is able to cook at home

□ YES □ NO

FOOD STORAGE AND COOKING RESOURCES *(check all that apply)*

Grocery recipient will have access to:

- ❑ Refrigerator
- ❑ Stove
- ❑ Microwave
- ❑ Oven
- ❑ Freezer
- ❑ None

ADDITONAL INFORMATION

Gender

- ❑ Female
- ❑ Male
- ❑ Transgender, Female to Male
- ❑ Transgender, Male to Female
- ❑ Other, Not Disclosed

Race/Ethnicity

- ❑ African American
- ❑ Asian
- ❑ American Indian or Alaska Native
- ❑ Hispanic or Latino/a
- ❑ Native Hawaiian or Pacific Islander
- ❑ White
- ❑ Other

REFERRAL CONTACT INFORMATION (person completing this form)

_____

Name Title

_____

Phone Number Email

May we contact you regarding any issues that may arise concerning this client? □ YES □ NO

I certify that the information here is accurate, that I have spoken with this patient and that they have agreed to be contacted by and receive services from Community Servings. □ YES □ NO

_____

Signature and Date

Please submit completed referral form to secure fax: 617.522.7770

Questions? Call 617-522-7777 ext 222 to speak with Carmenmari Zaballa.