

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:	<input checked="" type="checkbox"/> 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	<input type="checkbox"/> General Wellness/Protein+	
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)	<input type="checkbox"/> Stroke (I63.9)		
<input type="checkbox"/> COPD (J44.9)	<input type="checkbox"/> Cancer (C80.1)	<input type="checkbox"/> Hypertension (I10)		
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.				