

HOME-DELIVERED MEAL INFORMATION SHEET

Today's Date: _____

Referred By: _____

ELDER CONTACT INFORMATION

Last Name: _____

First Name: _____ MI: _____

Street Address: _____

City: _____ State: _____

Zip Code: _____

Directions to Home/Color of House / Cross Streets / Identifying Landmarks:

Does the elder own dogs that could interfere with the delivery? Yes No

May the delivery person enter the elder's home after knocking, without waiting for a response from the elder? Yes No

Phone: _____

Sex: Female Male

Date of birth: _____

Elder is unable to leave home without assistance because: _____

MEAL INFORMATION

Number of meals to be delivered per week: _____

Type of meal: Hot Frozen

Special considerations: No sweets No Bread No Milk

Other Special Instructions (Allergies/Food Preferences): _____

PHYSICAL CONDITION

Physician Name: _____

Physician Phone: _____

Medications: _____

Height: _____

Weight: _____

Do you sometimes lose interest in things you used to enjoy? Yes No

Elder should be re-checked in: 3 Months 6 Months _____ Months

DIASTER or EMERGENCY INFORMATION

In emergency, elder should be priority: 1 (High) 2 3 (Low)

Does elder need emergency water? Yes No

CAREGIVER INFORMATION

Caregiver Name and Schedule: _____

Caregiver is: Paid Unpaid Related Not Related

Signature: _____