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

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Referral Form

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Client Services

GENERAL INFORMATION *required*

Client is referred for: ☐ **Nutrition Counseling** ☐ **Meal Delivery** ☐ **Both** **Date of Birth:** _____/_____/______

Name First **:**_______________________________ Last: _______________________________ Preferred:

Street Address: ____ **Apartment:** ___________

City: _______________________________ **State:** ______ **Zip Code:** __________ **Phone:** (______)_______-__________

Alt Phone: (______)_______-__________ **E-Mail Address:** ______________________________

Emergency Contact Name: ___________________________________ **Emergency Contact Phone:** (______) _______-________

Gender: Cis female Cis male Transwoman (male to female) Transman (female to male) Non-binary Self-identify:

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:** ________

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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 for Assistance with Meal Delivery** (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:** ___________

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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)

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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): ______________________ ___

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

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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)			

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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

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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

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