Food Outreach
3117 Olive Street
St. Louis, MO 63103
Phone: 314-652-3663

Cancer Client Intake Form

Please fax this form to Food Outreach 314-652-3673

Name:		**Today's Date**	**DOB:**
Address:	**City**	**State**	**Zip**
Phone:	**Alternate Phone:**	**Best Time to Call:**	**SSN:**

Gender:
[ ] Male
[ ] Female
[ ] Transgender

Race:
[ ] Black/African Amer. [ ] White [ ] Asian
[ ] Am.Native/Alaskan Native
[ ] Native Hawaiian/Pacific Islander
[ ] Am. Indian/Alaskan Native & White [ ] Asian & White [ ] Black/African American & White [ ] Amer. Ind./Alaskan Nat. & Black [ ] Other Multi-Racial [ ] Other [ ] Unknown

Ethnicity:
[ ] Hispanic
[ ] Non-Hispanic

Diet Order:
Food Allergies/Intolerances/Religious Restrictions:

Food Stamp Eligible: [ ] Yes [ ] No	**Food Stamp Amount:**	**# of claimed dependants living in household/ages**

Cancer Diagnosis: _____ **Date DX:** ___/___/___

Treatment plan:
[ ] Surgery [ ] Radiation [ ] Chemotherapy

Treatment Dates:

Relevant Medical History:

Medicaid:
[ ] Yes [ ] No [ ] Pending [ ] Spend down
[ ] Unknown [ ] MC+ [ ]Denied

Medicare:
[ ] Part A [ ] Part B [ ] Part D

Other/Private Insurance Company:

PRINT NAME of Referring Physician/Social Worker/Nurse/RD/Patient Navigator and Location:

X

Signature of Referring Physician/Social Worker/Nurse/RD/Patient Navigator and Location:

X

Phone:

Fax:

Email:

Treating Oncologist and Location/Hospital:

Phone:

Fax:

Household Income: _____
Household size: _____

Poverty Level:
[ ] 300% [ ] 200% [ ] 100%

Please describe any special needs or circumstances:

NOTE: Referring health care worker or patient may call to schedule intake appointment, or patient will be contacted as soon as possible. 314-652-3663 Dietitian: x112 Director of Client Services: x111