Food Outreach

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

Cancer Client Referral Form

Please fax this form to Food Outreach at 866-737-9858

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

Select all that apply: [ ] Male [ ] Female [ ] Transgender [ ] Non-binary	**Race (select all that apply):** [ ] Black/African Amer. [ ] White [ ] Asian [ ] American Indian/Alaskan Native [ ] Native Hawaiian/Pacific Islander [ ] 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: **Signature of Referring Physician/Social Worker/Nurse/RD/Patient Navigator*** **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:**

***By submitting this application, you are confirming that your patient / client has provided verbal consent for their personal health information to be shared with Food Outreach.**

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 x1113 (Rachel) or x1112 (Melissa)