Food Outreach

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

Cancer Client Referral Form

Submit referral electronically at https://foodoutreach.org/client-services/
OR fax completed form to Food Outreach at 866-737-9858

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

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

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:

Phone:

Fax:

Signature of Referring Physician/Social Worker/Nurse/RD/Patient Navigator*
X

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: Once referral has been received, we will attempt 3 times to contact the client to schedule an intake appointment. The client may call us to schedule directly: 314-652-3663 x1119 (Intake Coordinator) x1113 (Dietitian) or x1112 (Dietitian)