Food Outreach

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

HIV/AIDS 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:** Referral valid for 6 months from this date	**DOB:**
Address:	**City:**	**State:**	**Zip:**
Phone:	**Alternate Phone:**	**DCN/Ryan White Number:**	

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

Desired Pantry Access:
[ ] Food Outreach [ ] MadCAP

Ryan White Eligible: [ ] Yes [ ] No

Status: [ ] HIV [ ] AIDS	**Diagnosis date:**	**CD4:**	**Test Date:**	**Viral Load:**	**Test Date:**	**TB Test:** [ ] Positive [ ] Negative	**TB Test Date:**

Receiving Food Stamps: [ ] Yes [ ] No	**Food Stamp Amount:**	**Number of dependants living in household/ages:**

HIV/AIDS Adult Risk Factor: [ ] Men who have sex with men (MSM) [ ] Injection Drug User (IDU) [ ] MSM and IDU [ ] Hemophilia [ ] Heterosexual (male and female) [ ] Blood Transfusion [ ] Unknown [ ] Other	**HIV/AIDS Pediatric Risk Factor:** [ ] Sexual Abuse [ ] Perinatal transmission [ ] Hemophilia [ ] Unknown [ ] Other
Medicaid: [ ] Yes [ ] No [ ] Applied [ ] Spend down [ ] Unknown [ ] MC+	**Medicare:** [ ] Part A [ ] Part B

Other Insurance Company:

Case Manager:	**Agency:**	**Phone:**
HIV/AIDS Physician:	**Clinic:**	**Phone:** **Fax:**

Household Income: _____ **Household size: _____** **Poverty Level:** [ ] 300% [ ] 200% [ ] 100%	**Please describe any special needs or circumstances including food allergies and/or special diets:**

***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)