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:		**DOB:**	**Today's Date:**
Address:	**City**	**State**	**Zip**
Phone:	**Alternate Phone:**	**Best Time to Call:**	**Preferred Language, if not English:**

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: _____	**Ethnicity:** [ ] Hispanic [ ] Non-Hispanic

Cancer Diagnosis: _____ **Date DX:** ___/___/___ **Treatment plan:** [ ] Surgery [ ] Radiation [ ] Chemotherapy **Treatment Start Date:**	**If known, please specify treatment medication(s) or regimen name(s):**
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, circumstances or pertinent past medical history:**

***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 to contact the client to schedule an intake appointment. The client may call us to schedule directly: Intake Coordinator 314-710-5543 or one of our Dietitians at 314-710-5545 or 314-710-5530