



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:		DOB:		Today's Date:	
Address:			City:		State: Zip:
Phone:	Alternate Phone:	Last 4 of SSN (<u>IL clients only</u>):		DCN/Ryan White # (<u>MO clients only</u>):	
Select all that apply: <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Transgender <input type="checkbox"/> Non-binary		Race (select all that apply): <input type="checkbox"/> Black/African Amer. <input type="checkbox"/> White <input type="checkbox"/> Asian <input type="checkbox"/> American Indian/Alaskan Native <input type="checkbox"/> Native Hawaiian/Pacific Islander <input type="checkbox"/> Other: _____		Ethnicity: <input type="checkbox"/> Hispanic <input type="checkbox"/> Non-Hispanic	
Desired Pantry Access: <input type="checkbox"/> Food Outreach <input type="checkbox"/> MadCAP			Ryan White Eligible: <input type="checkbox"/> Yes <input type="checkbox"/> No		
Status:	Diagnosis date:	CD4:	Test Date:	Viral Load:	Test Date:
<input type="checkbox"/> HIV <input type="checkbox"/> AIDS					
Receiving Food Stamps: <input type="checkbox"/> Yes <input type="checkbox"/> No		Food Stamp Amount:		Preferred Language, if not English:	
HIV/AIDS Adult Risk Factor: <input type="checkbox"/> Men who have sex with men (MSM) <input type="checkbox"/> Injection Drug User (IDU) <input type="checkbox"/> MSM and IDU <input type="checkbox"/> Hemophilia <input type="checkbox"/> Heterosexual (male and female) <input type="checkbox"/> Blood Transfusion <input type="checkbox"/> Unknown <input type="checkbox"/> Other			HIV/AIDS Pediatric Risk Factor: <input type="checkbox"/> Sexual Abuse <input type="checkbox"/> Perinatal transmission <input type="checkbox"/> Hemophilia <input type="checkbox"/> Unknown <input type="checkbox"/> Other		
Medicaid: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Applied <input type="checkbox"/> Spend down <input type="checkbox"/> Unknown <input type="checkbox"/> MC+			Medicare: <input type="checkbox"/> Part A <input type="checkbox"/> Part B		
Other Insurance Company:					
Case Manager:		Agency:		Phone:	
HIV/AIDS Physician:		Clinic:		Phone: Fax:	
Household Income: _____ Household size: _____ Poverty Level: <input type="checkbox"/> 300% <input type="checkbox"/> 200% <input type="checkbox"/> 100%			Please describe any special needs, circumstances or pertinent past medical history:		
<p>*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.</p> <p>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</p>					

