MEALS ON WHEELS ROCKHAMPTON INCORPORATED

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FRENCHVILLE 4701
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RUN #__________ (OFFICE USE ONLY)

Name: ____

Address: ____

____

Desired Service Commencement: ____

Date of Birth: ___/___/___ **Phone:** ___________________________

Marital Status: ______________________________ **Gender:** M ☐ F ☐

Living Alone? Yes ☐ No ☐ If No, who else live in the home? ______________________

Indigenous Status: Aboriginal ☐ Torres Strait Islander ☐ Neither ☐

Country of Birth: _______________________ **Primary Language Spoken:** __________________

1. **Emergency Contact:** ____

   Relationship to Client:____

   Phone: ____

2. **Emergency Contact:** ____

   Relationship to Client:____

   Phone: ____

Doctor: ____**Phone:**____________________

Medical Condition / Disability: ____

Food Allergies / Special Diets: ____

Number of Meals per Week: _____________ **Days of the Week:** _________________________

Veterans Affairs Card Holder: Yes White/Gold No

Aged Pension: Y / N **Disability Pension:** Y / N **Full Cost:** Y/N

PENSION NUMBER: ____

MEDICARE NUMBER: ____**REF#**____________

MY AGED CARE NUMBER: _________________________________
PACKAGE PROVIDER NAME: _________________________________

CONSENT TO REFER TO MAC: ☐ **Referral Sent:** ____/____/___ **REF #**________________

NDIS NUMBER: ______________________________________**Start Date:**___________________

Invoice to: ____

WHS Checklist:

Entrance to property: Front☐ Back☐ **Stairs:** Yes ☐ No☐

Dog/s on property:☐ (restrained) **Fridge accessible to volunteer:** Yes ☐ No☐

Trip Hazards : Yes ☐ No☐

Comments:

Referring Agency (if applicable)**:** ____

Case Manager: ____**Phone:** _______________________

Date of Referral: _________________________

Disclaimer:

Whilst Meals on Wheels endeavour to provide the best quality and service to our consumers and meet all government standards, Meals on Wheels will not be responsible or liable, under any circumstances, for any illness or health problem that may result from the incorrect consumption of its prepared foods, meals, or other products.

Meals on Wheels may not be appropriate for certain people including people;

1) who have severe food allergies; or
2) suffer from a medical condition that can be adversely affected by diet.

If the client does not respond to a scheduled visit Meals on Wheels will endeavor to contact an Emergency contact as allocated on this referral form

Home visits will be scheduled one month from start of service.

Office Use Only:

POLIXEN ☐ WELCOME PACK ☐ MAC REFERRAL ☐

FOLLOW UP CALL DATE ____________________ FOLLOW UP CALL COMPLETED ☐

CONSENT SIGNED AND RETURNED ☐

CHARTER OF AGED CARE SIGNED AND RETURNED ☐ DELIVERY RISK ASS DONE ☐