Community Supports/ILOS referral form
(For Medi-Cal/Partnership recipients only.)

Fax this form and patient's recent progress note with problem list (complete with ICD-10 codes) and medication list to:
(707) 887-1440 (HIPAA Compliant Fax)
Questions: Angel Becerra RDN (707) 887-1647 ext. 110

Consent to Release Information

I authorize my medical providers and referring party to release information about my medical condition to Food For Thought for the purpose of enrolling in and receiving ongoing food bank services.

Patient Name: ________________________________ Date of Birth: ____/______/_____

❑ Medi-Cal ID #_______________________

❑ Interested in program ❑ Reliable communication ❑ Able to store and prepare food

Patient signature ________________________________Date _______________

Patient Information

Address _________________________City/Town: __________________ Zip: _______
Phone: ____________________ Okay to leave message? ❑ yes ❑ no

Gender: ❑ Female ❑ Male ❑ Transgender ❑ Other _____________

Primary language: ❑ English ❑ Spanish ❑ Other _____________

Emergency contact: ________________ Phone: ___________ Relationship: _________

MAJOR HEALTH ISSUE(S):____

REASON MEDICALLY TAILORED GROCERIES WILL BENEFIT PATIENT'S HEALTH AND LIKELY REDUCE THE NEED FOR OTHER MEDICAL SERVICES:

____

____

Current health status ______________________

Primary doctor / medical home ____

Risk factors: ❑ Living alone or w/o care ❑ Homebound ❑ Unable to prepare food

❑ Mental health condition_______________ ☐ Other __________________________

Referrer Information (Referrer must be an MD, DO, NP, PA, RN, RD, MSW, or LSCW)

Name of Referrer / Title ____________________________/____________________

Name of hospital or health center___________________________ Phone ______________

❑ I **have assessed this patient's eligibility and received their consent to be referred**

Referrer's signature____________________________________ Date_____________