Food For Thought
healing with food+love

HIV/AIDS Referral Form

Fax this form with HIV positive result to:
(707) 887-1440 (HIPAA Compliant)
Questions: Call Client Services at (707) 887-1647 ext. 127

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: _____/_____/_____

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

Patient signature _____ Date _____

Patient Information

Address _____ City/Town: _____ Zip: _____
Phone: _____ Okay to leave a message? ☐ Yes ☐ No

Gender: ☐ Female ☐ Male ☐ Transgender ☐ Other _____

Primary language: ☐ English ☐ Spanish ☐ Other _____

Emergency contact: _____ Phone: _____ Relationship: _____

HIV/AIDS diagnosis: _____

Other medical concerns? _____

Primary doctor / medical home _____

Risk factors: ☐ Living alone or w/o care ☐ Unable to prepare food ☐ Unstable Housing

☐ Mental health condition_____ ☐ Other _____

Medi-Cal Number _____ (if applicable)

Referrer Information

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_____