Food For Thought
healing with food+love

Community Supports/ILOS Referral Form

(For Medi-Cal/Partnership members only)

Fax this form with patient's recent Progress Note with problem list and medication list 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 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 a 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: _____

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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_____