Food For Thought
healing with food+love

Infectious Disease Program Referral Form

COVID/MPOX/TB Food Program

Fax this form and patient's positive test 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 food bank services.

Patient Name: _____ Date of Birth: _____/_____/_____

Positive test date: _____/_____/_____ Length of time client likely to need services: _____

Client unable to access food during isolation:

☐ Financial reasons ☐ Other (please specify): _____

Number in household needing groceries: _____

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

Date client verbally consented to be referred: _____/_____/_____

Patient Information

Address: _____ City/Town: _____ Zip: _____

Phone: _____ Okay to leave a message? ☐ Yes ☐ No

Secondary contact: _____ Phone: _____

Gender: ☐ Female ☐ Male ☐ Transgender ☐ Other: _____

Primary language: ☐ English ☐ Spanish ☐ Other: _____

Primary doctor / medical home (if known): _____

Risk factors for malnutrition: ☐ Living alone or w/o care ☐ Homebound

☐ Unable to prepare food ☐ Mental health condition: _____

☐ Other: _____

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Referrer Information

Name of Referrer / Title: _____/_____

Name of health center/other facility: _____

Phone: _____ Fax: _____

☐ **I affirm that this patient has tested positive for this infectious disease and I received his/her/their consent to be referred.**

Referrer's signature_____ Date_____