INNER WEST COUNCIL

Tom Foster Community Care
Meals on Wheels Referral Form

Completed forms are to be posted to 11-13 Darley Street, Newtown 2042 or faxed to 9550 6832.
Phone: (02) 9335 2153

Client Details:

Last name: Title: Miss Ms Mrs Mr

First name: Gender: Date of Birth:

Address:

Accommodation: Owned home ☐ Private Rental ☐ Public Rental ☐ ☐ Other_____

Living: Alone ☐ Partner only ☐ Relatives/Other persons ☐

Phone no/s: Nearest Cross Street:

Country of Birth: Pension: Age ☐ DVA ☐ Disability☐ N/A☐

Ethnicity: Language spoken at home:

Does the client identify themselves as an Indigenous person? Yes ❑ No ❑

Have you ever received Meals on Wheels before? Yes ❑ No ❑ Detail:

Why is assistance needed with meals?

Is the client receiving other assistance? e.g. CHSP

Who is providing this service? How often do they assist the client?

Eligibility:

Does the person have impaired functional ability? Yes ❑ No ❑ If so, in what areas:

Self care☐ Mobility☐ Domestic tasks☐ Shopping/Cooking☐

Does the person have a disability? Yes ❑ No ❑ Disability:

Is the person a carer? Yes ❑ No ❑ Does the person have a carer? Yes ❑ No ❑

Does the person fulfil eligibility criteria & live in the appropriate LGA? Yes ❑ No ❑

Referred by:

Self or Name: Relationship to client:

Organisation: Address:

Phone no/s:

Has consent been given by the client for the referral? Yes ❑ No ❑

Date of referral: Signature of referrer:

Note: If referred by a service provider, ask if they have made the referral through MyAgedCare

Next of kin or nominated contact:

Next of kin/nominated contact person:

Relationship: Phone no/s:

Address: Postcode:

Does the person have an advocate or legal guardian? Yes ❑ No ❑

Name: Phone no/s:

Delivery details:

Any other special delivery details and/or safety issues? Yes ❑ No ❑

_____

(Note - for food safety reasons meals cannot be left outside a client's home. The client or a nominated person must be available to receive the meal. If not, the meal will be returned to TFCC.)

Any relevant disability or dysfunction that would impact on the client being able to answer the door to receive the meal? e.g. mobility, hearing difficulties:_____ Yes ❑ No ❑

Is the residence a boarding house? Yes ❑ No ❑

If there are any animals are they fenced in or can they be tied up? Yes ❑ No ❑ N/A ❑

Is there a history of challenging behaviour? Not known ❑ No ❑ Yes ❑

Provide details: _____

Meal requirements:

No. of main meals no. of sandwiches no. of desserts no of juices

Total cost per week $ _____

Type of meal: Frozen ❑ Chilled ❑ Hot - to be eaten immediately ❑

(for food safety reasons the delivery of hot meals is only recommended for clients who are unable to heat their own meals.)

To be delivered on: Mon ❑ Tues ❑ Wed ❑ Thurs ❑ Fri ❑

If more than one meal to be delivered per day please specify:

Preferred start date:_____ Meals required for how long?_____

Payment method: invoices are issued on a fortnightly basis in arrears

Meals to be paid by: Direct Debit ❑ Cheque ❑ Money Order ❑ Cash ❑ Credit Card ❑

By whom: Phone no/s:

Weekly or fortnightly: **Note direct debit is fortnightly**

Special diets:

It may be possible to cater for individual's special dietary needs. If a special diet is required for any medical, cultural or religious reasons please indicate what type of diet this is:

Puree ❑ Minced/Mashed ❑ Easy Chew ❑ Bland ❑ Diabetic ❑ Vegetarian ❑ Low Fat ❑

Other ❑ please specify: _____

Food allergies:

MyAgedCare (if eligible)

MyAgedCare explained to client/advocate: ❑

Consent obtained to refer to MyAgedCare: ❑

Client/advocate advised that they will be contacted by MyAgedCare: ❑

Data entered, MyAgedCare Reference Number: _____