



BRANCH \_\_\_\_\_

Date Received \_\_\_\_\_

**Meals on Wheels Client Referral Information**

CLIENT'S FULL NAME: Mr/Mrs/Miss/Ms \_\_\_\_\_

ADDRESS \_\_\_\_\_

PHONE NO \_\_\_\_\_ DATE OF BIRTH \_\_\_\_\_

REFERRED BY: Name and phone number \_\_\_\_\_

EMERGENCY CONTACT \_\_\_\_\_ PHONE \_\_\_\_\_

NOK or DOCTOR \_\_\_\_\_ PHONE \_\_\_\_\_

COMMENCE ON \_\_\_\_\_ DAYS REQUIRED \_\_\_\_\_

**MEAL PLAN:**

**LUNCH** -  SOUP  MAIN COURSE  SWEETS  SANDWICH

**TEA** -  SOUP  MAIN COURSE  SWEETS  SANDWICH

SPECIAL DIET \_\_\_\_\_

**\*YOU WILL NEED TO BE HOME TO COLLECT YOUR MEAL BETWEEN APROX. 10AM – 12.30PM**

WEEKLY COST \$

PAYMENT METHOD

CLIENT ADVISED OF CSO VISIT ✓

Client Contacted Date

Branch Advised Date

FOR THE SAFETY OF OUR VOLUNTEERS	
ARE THERE ANY DOGS AT YOUR HOME?	
IF YES – CAN THEY BE SECURED?	
WILL THERE BE ANYONE ELSE AT YOUR HOME?	
IF YES - WHO	
ARE THERE ANY FIREARMS AT THE PROPERTY?	
ANY OTHER ISSUES WE NEED TO BE AWARE OF THAT MAY HINDER ACCESS TO YOUR PROPERTY	
DELIVER INSTRUCTIONS/DIRECTIONS	

**Please email or fax this form to your Client Services Officer within one day of starting.**