Meals on Wheels

Meals on Wheels Client Referral Information

BRANCH _____

DATE _____

My Aged Care No. AC _____

NDIS number *if applicable* _____

Home Care Package Provider *if applicable* _____

CLIENT'S FULL NAME: Mr/Mrs/Miss/Ms _____

ADDRESS _____

PHONE NO _____ DATE OF BIRTH _____

REFERRED BY: Name and phone number _____

NOK or EMERGENCY CONTACT _____ PHONE _____

ADVOCATE or POA _____ PHONE _____

MEDICAL CONDITIONS *that may impact clients decision making* _____

COMMENCE ON _____ DAYS REQUIRED _____

MEAL PLAN: ☐ SOUP ☐ MAIN COURSE ☐ SWEETS ☐ SANDWICH

SPECIAL DIET _____

***YOUR MEAL WILL BE DELIVERED BETWEEN 10AM – 1.00PM**
***PLEASE LEAVE OUT AN ESKY WITH ICE BRICK IF YOU ARE NOT GOING TO BE HOME AT THIS TIME**

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?	
ARE THERE ANY FIREARMS AT THE PROPERTY?	
ANY OTHER ISSUES WE NEED TO BE AWARE OF THAT MAY HINDER ACCESS TO YOUR PROPERTY	
WILL THERE BE ANYONE ELSE AT YOUR PROPERTY? – IF YES WHO	
DELIVER INSTRUCTIONS/DIRECTIONS	

Please email or fax this form to your Client Services Officer 3 days prior to starting.