CFH Office Use: Date Received: ___________ Date Enrolled: ___________ End Service Date: __________

Cuisine for Healing- Referral Intake Form

Intake Date: ______________ HHS Poverty Level 150% or below (based on entire household income):
YES ☐ NO ☐

Referring Facility: ___________________________________ Contact Person: ______________________________

Phone: ___________________________________ Email: ____
Preferred Contact Method: phone ☐ email ☐

Client Information

First Name: ____________________________ MI: ____ Last Name: ___________________________________

Address: ____

City: ____ State: ________________ Zip Code: _________________

Contact Phone: ________________________________ Email: ____

Language: _____________________________________ Gender: ________ DOB: _____________

Marital Status: _______________________________ Ethnicity: ____________________ Veteran ☐

# of Children in Household: ☐ Infant-8yrs. ____ ☐ 9-16 yrs. ____

Secondary Contact: _____________________________ Relationship: ______________________________

Phone Number: ________________________________ Email: ____________________________________

Medical Information

Diagnosis: ____

Treatment Facility: ___________________________________ Referring Doctor: _____________________________

Current or Planned Treatment:
☐ Surgery Type: _______________ Date: _______________ ☐ Other: _________________________________

Food Allergies: ____
Other Health Conditions: ____

Please indicate Client Status*:

EMERGENCY ☐ (urgent + life threatening, post- surgery, no other means)
URGENT ☐ (acutely ill, no family support, no transportation)
NEED ☐ (qualifies financially and dealing with treatment and/or life threatening illness)

*Please contact our office you need assistance with this section.

Email: referral@cuisineforhealing.org
Fax: 800-983-4989
We will contact you once the referral is received by the Cuisine for Healing staff.