Client Services Department
Phone: 212-294-8102
Fax: 212-294-8198
Email: clients@glwd.org

Use this form to refer clients to the "Healthy Starts Program" only! (For gestational diabetes)

God's Love We Deliver Referral Form

Medical Nutrition Therapy and Meal Delivery Service

God's Love We Deliver provides medical nutrition therapy and medically tailored home-delivered meals for individuals living with severe illness in the New York City metropolitan area and Hudson County, NJ.

Page 1 of this form is to refer an individual or self-refer to God's Love. A **healthcare professional** (MD, NP or PA) must confirm an individual's **medical diagnosis on Page 2** for the individual to qualify.

Referral Information

This section is to make a referral for someone other than yourself.
If you are the client, move to **Client Information.**

Referral Source: ☐ Family Member ☐ Social Worker ☐ Case Manager ☐ Other___________________

Referrer Name: ___________________________________ **Title/Relationship:** ________________________

Agency/Hospital *(if applicable)*: ____

Ph: ___________________ **Fax:** ___________________ **Email:** ______________________________________

Client Information

Client Name: ____ **DOB:** ___________________

Ph: _____________________ **Cell:** _____________________ **Email:** __________________________________

Address: ____

____

Resides: ☐ Alone ☐ w/ Partner ☐ w/ Family ☐ w/ Dependents under 18 (How many? _____)

Gender: ☐ Male ☐ Female ☐ Transgender / M ☐ Transgender / F **Sex Assigned at Birth:** ____________

Race: ☐ White ☐ Black or African American ☐ Asian ☐ Native Hawaiian/Pacific Islander ☐ American Indian or Alaska Native

☐ Other ________________________ ☐ Prefer not to answer

Ethnicity: ☐ Hispanic/Latino ☐ Non-Hispanic/Latino ☐ Prefer not to answer

Language: ☐ English ☐ Spanish ☐ Other: __________________________

Emergency Contact: ____________________________________ **Relationship:** _______________________

Ph: ______________________________ **Email:** ____

Note: Please include the emergency contact on the HIPAA form. If the client has a Health Care Proxy or Power of Attorney, please provide supporting documentation. This is a requirement with a diagnosis of dementia.

A healthcare professional must complete the **next page**.

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Use this form to refer clients to the "Healthy Starts Program" only! (For gestational diabetes)

Medical nutrition therapy and home-delivered medically tailored meals are needed for:

CLIENT

Date: _______________

Name:________________________________ DOB: _________ Ph:________________ Cell: ________________

Address:____

____

MATERNAL/FETAL HEALTH

Maternal Health:

- ☐ Anemia
- ☐ Hypertension/preeclampsia
- ☐ Cholesterol/Triglycerides
- ☐ Hyperemesis gravidarum
- ☐ Hepatitis
- ☐ HIV
- ☐ Endocrine disorder
- ☐ Other medical conditions/STI __________________

Labs:

A1C: ____________________

Glucose: _________________

Ketones: _________________

Fetal Health:

- ☐ Intrauterine Growth Restriction
- ☐ Small for Gestational Age (SGA)
- ☐ Large for Gestational Age (LGA)
- ☐ Other: __________________________

MEDICAL DIAGNOSES

Primary Medical Diagnosis: ____ Date of Dx:__________

Additional Medical Conditions:____

ICD-9/ICD-10 code(s): ____

Current Medications/Treatments: ____

Hgt:_____ Wgt: _____ Date:_______ Pre-pregnancy weight: ________

Estimated delivery date: _____________ Number of fetuses: _________

weeks gestation: ___________ # previous pregnancies: __________

Previous pregnancy complications: ____

Last pre-natal visit: ______________________

Current medications/supplements: ____

Food allergies: ____

HEALTHCARE PROVIDER

This form must be signed by an MD, NP or PA.

Healthcare Provider's Name: ______________________________ Title:_________ License #:___________

Healthcare Provider's Signature: _______________________________________ Date:________________

Facility/Hospital:____

Healthcare Provider Ph:________________ Fax:________________ Email:__________________________

***Certification:* I hereby confirm the information above is true and accurate.**

This is a 6 month program. The client will be served for 4 months of pregnancy and 2 months post-partum.