MEALS on WHEELS
WILSON COUNTY

PATIENT REFERRAL FAX FORM

Date: _____

No. Pages _____

To:	Meals on Wheels Wilson County		From:	
	2101 Tarboro St SW Suite C			
	Wilson, NC 27893			
Phone:	252-237-1303		Phone:	
Fax:	252-991-7034		Fax:	

REQUIRED INFORMATION FOR PATIENT REFERRALS

Patient Name: _____

Male ☐ Female ☐ DOB: _____ Last 4 Of SS#: _____

Phone: _____

Address: _____

_____

_____

Is the patient home bound? Yes ☐ No ☐ Is the patient **able** to drive? Yes ☐ No ☐

Is the patient physically/mentally able to participate in a congregate meal program? Yes ☐ No ☐

Has the patient been diagnosed with Alzheimer's or a related dementia? Yes ☐ No ☐

If so, who can we contact to assist with assessment?

Name: _____ Relationship: _____

Phone: _____