

**Burnaby Meals on Wheels Society
Client Referral Form**

Fax or mail completed copy to:

**Burnaby Meals on Wheels Society
#16 - 250 Willingdon Ave.
Burnaby, BC V5C 5E9
Fax: (604) 299-3755**

Name _____

Mailing Address _____

Postal Code _____

Telephone (____) _____

Birth Date (M/D/Y) _____

Referred by: _____

Agency: _____

Reason for Referral: _____

Contact Information:

Contact Name: _____

Relative _____ Friend _____ Other _____

Relationship:

Address: _____

Postal Code: _____

Telephone: (____) _____

Billing Information:

Name: _____

Address: _____

Postal Code _____ Phone (____) _____

Health Information:

Name of Doctor _____

Telephone (____) _____

Hearing: Good ___ Poor ___ Deaf ___

Sight: Good ___ Poor ___ Blind ___

Mobility: Good ___ Fair ___ Poor ___

Mental State:

Good ___ Forgetful ___

Confused ___ Alzheimer's ___

Short Term Memory Loss ___

Requires help setting up meals

Yes ___ No ___

Diet Requested:

Regular ___ Low Sodium ___

Diabetic ___ High Protein ___

Minced ___ Low Fat ___

Delivery days Requested:

Please indicate how many hot and or frozen meals as well as Bag Lunches required for each delivery day.

Monday:

Hot ___ Frozen ___ Bag Lunch ___

Wednesday:

Hot ___ Frozen ___ Bag Lunch ___

Friday:

Hot ___ Frozen ___ Bag Lunch ___