CERES COMMUNITY PROJECT

Medical Referral Form

Delivered to your home, free of charge

CeresProject.org

Ceres Standard Menu Nutrition Guidelines Per Meal

Calories: 500-700 kcal
Sodium: <800 mg
Total Fat: 23-31 grams
Saturated Fat: 6-9 grams
Protein: > 25 grams
Carbohydrate: <60 grams
Fiber: 8-9 grams
Potassium: 585-1,950 mg
Vitamin K: 390-1250 mcg per week

Health Care Provider

Fax: 707.324.3828 (HIPAA Compliant)
Questions: clientcareteam@ceresproject.org

Please complete all information below to the best of your ability.

PATIENT INFORMATION

First Name: Last Name: Date of Birth: Medi-Cal Subscriber #:
Cell Phone #: Home Phone #: County: Insurer:
Preferred Language: Interpreter Required? ☐ Date of Last Primary Care Visit (MM/YY): ☐ Unsure

ELIMINATING CONDITIONS

☐ I certify that patient **DOES NOT** have End Stage Kidney Disease (on dialysis), Gestational Diabetes or Celiac Disease, **IS NOT** taking Coumadin/Warfarin* and **IS NOT** on hospice.

☐ **Unsure**, check with patient

PHYSICAL DATA

Current Weight: Height: ft. in.

DIAGNOSES DATA *(Check all that apply)*

Diabetes: ☐ Type I ☐ Type II Controlled: ☐ Yes ☐ No On Insulin: ☐ Yes ☐ No
Most Recent HbA1c: Date: Most recent FBG level: Date:

☐ Chronic Kidney Disease* (not on dialysis)
Stage: eGFR:

☐ Coronary Artery Disease ☐ Congestive Heart Failure ☐ Hypertension ☐ Stroke ☐ Diverticulitis ☐ IBD/IBS

☐ Cancer Type: Receiving Treatment: ☐ Yes ☐ No

☐ Chronic Obstructive Pulmonary Disease ☐ Malnutrition ☐ Obesity ☐ Hepatitis C ☐ HIV/AIDS

☐ Neurological Disorder (please list):

☐ Mental Health Disorder (please list):

**Note: If client has CKD or takes Coumadin/Warfarin, Ceres standard menu must be approved by physician: ☐ Standard Menu Approved*

OTHER COMORBIDITIES

Other medical conditions not listed above (please list all that apply):

EMERGENCY DEPARTMENT UTILIZATION

In the past 3 months, how many times did the patient **VISIT** a hospital emergency department? ☐ Unsure

In the past 3 months, how many times did the patient **STAY** in a hospital overnight or longer? ☐ Unsure

PHYSICIAN / REFERRER AUTHORIZATION

Referrer's Name: Title: Date:
Medical Provider's Name: Medical Provider's Title/Role (MD, NP, PA, ED, RN, or LCSW):
Phone #: Email:
Affiliation/Organization: Referrer's Signature:
Additional Comments:

The information requested above is Protected Health Information (PHI) and is the minimum necessary to execute delivery of patient services. Please understand as a link in the "Claim of Trust", all PHI will remain confidential as mandated by the Treatment, Payments, and Healthcare Operation Laws mandated by HIPAA.