



# Client Registration Form

## Meals on Wheels Program

Date Taken: \_\_\_\_\_

Start Date: \_\_\_\_\_

### How did you learn about our Meals on Wheels Program?

\_\_\_\_\_

Mr. \_\_\_\_\_ Mrs. \_\_\_\_\_ Ms. \_\_\_\_\_ Miss. \_\_\_\_\_ Date of Birth: \_\_\_\_\_

First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_

Phone #: \_\_\_\_\_ Cell #: \_\_\_\_\_

Address: \_\_\_\_\_ Postal Code: \_\_\_\_\_

City: \_\_\_\_\_ Email: \_\_\_\_\_

Location Details/Which entrance should volunteers use?: \_\_\_\_\_

\_\_\_\_\_

Are you a Veteran? Y\_\_\_\_/N\_\_\_\_ If yes, please provide your Veterans Affairs # \_\_\_\_\_

Do you live alone? Y\_\_\_\_/N\_\_\_\_ With Whom? \_\_\_\_\_

**Meal Details:** **MON** \_\_\_\_\_ **TUES** \_\_\_\_\_ **WED** \_\_\_\_\_ **THURS** \_\_\_\_\_ **FRI** \_\_\_\_\_

Extra meals for the weekend? **SAT** \_\_\_\_\_ **SUN** \_\_\_\_\_ (Receive 2 meals on Thursday & 2 meals on Friday)

Type of meal: *Regular* \_\_\_\_\_ *Diabetic* \_\_\_\_\_ *Gluten Free* \_\_\_\_\_ Allergies or food aversions? \_\_\_\_\_

\_\_\_\_\_

Any problems chewing or swallowing? Y\_\_\_\_/N\_\_\_\_ If yes, please select one of the options below:

*Chopped* \_\_\_\_\_ *Minced* \_\_\_\_\_ *Pureed* \_\_\_\_\_ *Dental Soft* \_\_\_\_\_

Send invoice to: Client? Y\_\_\_\_/N\_\_\_\_ OR ... Send to Third Party? Y\_\_\_\_/N\_\_\_\_

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Address: \_\_\_\_\_ Postal Code: \_\_\_\_\_

City: \_\_\_\_\_ Email: \_\_\_\_\_

**Emergency Contact #1:** \_\_\_\_\_ Relationship: \_\_\_\_\_  
Phone #: \_\_\_\_\_ Cell #: \_\_\_\_\_ Work #: \_\_\_\_\_  
Email or Address: \_\_\_\_\_

**Emergency Contact #2:** \_\_\_\_\_ Relationship: \_\_\_\_\_  
Phone #: \_\_\_\_\_ Cell #: \_\_\_\_\_ Work #: \_\_\_\_\_  
Email or Address: \_\_\_\_\_

**Clients Medical Information:** OHIP #: \_\_\_\_\_

General Physician's Name: \_\_\_\_\_

Phone #: \_\_\_\_\_ Address: \_\_\_\_\_

Are there any medical/health issues we should be aware of? Or has the client been hospitalized in the last few months? (heart/hearing/mobility) Y\_\_\_\_/N\_\_\_\_ If yes, please specify: \_\_\_\_\_

Does the currently receive services from the CCAC? Y\_\_\_\_/N\_\_\_\_ If yes, which & how often? \_\_\_\_\_

Does the client receive any other home support services? (VON, PSW, Life-Line etc.) Y\_\_\_\_/N\_\_\_\_ If yes, \_\_\_\_\_

Is the client already connected with one of Dundas Community Services programs? Y\_\_\_\_/N\_\_\_\_

If yes, please identify which Program: \_\_\_\_\_

If no, would the client be interested in learning about our other programs? Please specify: \_\_\_\_\_

Meals were ordered by: \_\_\_\_\_

Is the client aware meals are being ordered on their behalf? Y\_\_\_\_/N\_\_\_\_ (Clients must be agreeable)

**Form Completed By:** \_\_\_\_\_ **Date:** \_\_\_\_\_