AltaMed
QUALITY CARE WITHOUT EXCEPTION™

Referral Form
Ryan White Part D Women, Infant and Youth Nutrition Services

HIV knowledgeable registered dietitians work with clients to provide early and ongoing medical nutritional therapy. Goals and benefits of medical nutrition therapy in HIV care include: to optimize adequate intake of nutrients, preserve weight and lean body mass, minimize side effects, coordinate foods, meal and medication schedules to optimize drug levels and reduce risk of drug resistance, and evaluate complementary therapies.

Nutritional Screen

1. Without wanting to, I have lost 10 pounds or more in the last 6 months. Yes No
2. I have problems eating because of my current health status. Yes No
3. I have been stressed, sad, for a long time, or severely ill in the past 3 months. Yes No
4. I often have one or more of the following: (circle all that apply) Yes No
   Diarrhea, nausea, heartburn, bloating, vomiting, no/poor appetite, feel too tired
5. I have to watch what I eat because of a health problem like: (circle all that apply)
   Diabetes, high blood pressure, kidney or liver problems, cancer, high lipids Yes No
6. I find it difficult to move around Yes No

*Total number of yes's does not determine eligibility

Total number of YES answers: ☐

Today's Date: _____ Client's ARIES ID: _____

Client's Name: _____ DOB: _____

Client's Address: _____

City: _____ ZIP Code: _____

Client's Preferred Phone: ( ) _____ Call OK? Yes / No Discretion? Yes / No

Special Needs (wheelchair, impaired vision, cognitive issues, other): _____

ALL Four (4) CRITERIA MUST BE MET IN ORDER FOR THE REFERRAL TO BE ACCEPTED:

☐ *Client Part D eligibility :*
- ☐ *Female*
- ☐ *Male under 24 years*

☐ *Client's signed authorization which allows referring provider to disclose patient Protected Health Information (PHI) to Medical Nutrition provider is attached. Clients shall be informed of their right to: confidentiality in accordance with state and federal laws and informed consent.*

☐ *I, as the person making this referral, have ensured that eligibility has been verified and all required documents (verification of HIV and proof of residence within Orange County) are present and filed in the eligibility section of the client file at the referring agency.*

☐ *I, as the person making this referral, have ensured that Ryan White funds are the payer of last resort. Based on the information provided by the financial assessment and the client's self-report, the client is not eligible for the following:*
- ☐ *Nutrition Services*

Person Referring_____ Signature_____
Date

Referring Agency (circle one): 17th Street Care Clinic ASF Delhi Shanti OC Other: _____

Referring Agency's Phone: ( ) _____

***Please add ARIES Consent Form with Referral**

AltaMed 1155 W. Central Ave. Suite 104-107
Santa Ana CA 92707
Phone: 714 500 0491 Fax: 714-263-1548