

ROCKDALE MEALS SERVICE REFERRAL FORM

Completed forms are to be posted to:

PO BOX 64, Bexley 2207

Fax 9554 3313 E-mail pdaras@rockdale.nsw.gov.au

Client Details:

Last name: _____ Title: Miss Ms Mrs Mr

First name: _____ Gender: M /F Date of Birth: _____

Phone No: _____

Address:

Nearest Cross Street: _____

Accommodation: Owned home Private Rental Public Rental

Other _____

Living:

Alone Partner only Relatives/Other persons

Country of Birth:

Language spoken at home:

Pension: Age DVA Disability N/A

Referred By:

Self _____ Family _____

Organisation (State) _____

Clients GP: Name _____ Ph No _____

Emergency Contact:

Name _____ Ph No _____

Meals requirements: Please circle your choice.

Choices:

1. Monday - Friday Chilled Frozen Hot meals
(includes Main Soup Juice Dessert)

2. Weekend Frozen

3. Bulk Frozen

4. Delivery tailored to suit clients needs

5. Minced Pureed Diabetic Cutup Soft

6. SERVICE START DATE: _____