Referral Form – for Health Provider

Date: _____
Name of health referral provider: _____
Name of Market Greens delivery partner: **Kiwassa Neighbourhood House**

Market Greens is a local program offered by Kiwassa Neighborhood House. This program provides support to access fresh fruits and vegetables for people managing chronic, diet-related health conditions who have challenges making ends meet. The program is linked to the Pandora Community Food Market which has affordably priced fresh food options. Participants will be given 15 vouchers to use one time each week at this market only. The amount of the voucher is based on how many people live together in one house. If you agree to be assessed for this program, the first step is receiving a referral from a physician, registered nurse, nurse practitioner, or dietician. The second step would require you to answer a few additional questions directly with Kiwassa Neighbourhood House (there is a possibility that you might not be eligible at this time).

Are you still interested in continuing with this 2-step process?

☐ YES > *continue to question 1*

☐ NO > *end of questionnaire*

Confirmation of Diet-related illness

1. Are you currently managing any of the following health conditions:

☐ Coronary heart disease

☐ Stroke

☐ Hypertension (high blood pressure)

☐ Non-alcoholic fatty liver disease

☐ Obesity

☐ Type II diabetes

☐ Insulin resistance

☐ Impaired glucose tolerance

☐ Abnormal lipids (risk factor)

☐ Other: _____

2. I, the health provider, have assessed the individual and confirm that they are currently managing a diet-related illness:

☐ YES

☐ NO

3. Do you consent to have **Kiwassa Neighbourhood House** confirm this diagnosis with the health provider?
AND
Do you consent to be contacted by **Kiwassa Neighbourhood House** to arrange to complete your assessment?

☐ YES

☐ NO

>>>>** If answered **YES** to all questions please **COMPLETE THE FOLLOWING

PATIENT FIRST Name: _____

LAST Name: _____

Primary phone number: _____ Secondary number, if applicable: _____

Email contact, if preferred: _____

Patient signature: _____

I confirm that I have assessed the individual and have referred them for further screening for Market Greens.

Name of health provider making referral: _____

Stamp of health provider/signature: _____

***** PLEASE COPY FORM FOR PATIENT FILE *****
***** RETURN COMPLETED FORM TO PATIENT TO BRING TO KIWASSA *****

Kiwassa Food Program: 604-254-5401 ext. 253 / food@kiwassa.ca

community food centres CANADA good food is just the beginning

Kiwassa neighbourhood house