Information for clients starting Meals on Wheels

SECTION 1 – CLIENT INFORMATION

Start date ____ /____ /____ ☐ Mr ☐ Mrs ☐ Miss ☐ Ms ☐ Other__________________

Surname ________________________ First name(s) ________________________________

Address ____

____ Post code __________

Phone no. __________________________ Mobile no. __________________________

Delivery details (e.g. front door) ____

Dietary requirements (e.g. diabetic) ______________________________________

Number of meals per week (minimum 2) ____ ☐ Mon ☐ Tue ☐ Wed ☐ Thu ☐ Fri

Number of frozen meals for the weekend (if required) ____ Size of meal(s) ☐ Sml ☐ Med ☐ Lg

SECTION 2 – ALTERNATIVE CONTACT

Surname ________________________ First name(s) ________________________________

Address ____

____ Post code __________

Phone no. __________________________ Mobile no. __________________________

Relationship to client _______________________

SECTION 3 – TO BE COMPLETED IF PAYER IS NOT THE CLIENT

Payer name (if not client) ____

Address (to post account to) ____

____ Post code __________

Phone no. __________________________

TM10/18