



Complete this form and send back to info@foodservices.org.au.
If you have any questions about the referral process, please call us on (02) 9540 7365.

Date:	
1. CUSTOMER DETAILS	
Name:	Date of Birth:
Address:	
Phone Number:	Mobile Number:
Are you on a package? If so, who is the package with?	
What services is that package providing?	
Any Power of Attorney? Who is account to be sent to?	
How did you hear about us?	
Current <i>My Aged Care</i> Identification Number:	
Notes:	
2. MEAL DELIVERY INFORMATION	
<i>WHICH SERVICE ARE YOU INTERESTED IN:</i>	
Frozen Meal Delivery Yes <input type="checkbox"/> No <input type="checkbox"/> <i>(Approx. delivery time 9:30am - 11:45am)</i>	Hot Lunch Delivery Yes <input type="checkbox"/> No <input type="checkbox"/> <i>(Approx. delivery time 11:30am - 12:45pm)</i>
I am interested in:	I am interested in:
<input type="checkbox"/> Main Meals	<input type="checkbox"/> Main Meals
<input type="checkbox"/> Mini Meals	<input type="checkbox"/> Mini Meals
<input type="checkbox"/> Desserts	<input type="checkbox"/> Desserts
<input type="checkbox"/> Soups	<input type="checkbox"/> Soups
<input type="checkbox"/> Lunch / Breakfast Packs	<input type="checkbox"/> Lunch / Breakfast Packs
3. CONTACT DETAILS	
Contact 1:	Phone Number:
Relationship:	Email:
Contact 2:	Phone Number:
Relationship:	Email:
4. REFERRAL BY OTHER ORGANISATION (e.g. Hospital, Other Community Services)	
Name of Referrer:	Organisation:
Referrer Phone Number:	Referrer Email: