

Community Servings: Home Delivered Meals Program Certification Form

Applicant/Client Section: I hereby authorize my physician, nurse practitioner or physician assistant to release information regarding my medical condition to Community Servings for the purpose of verifying my eligibility:

Client Name

Signature

Date

Healthcare Provider Section:

Community Servings provides home delivered meals to clients at a critical stage of a life-threatening illness. On behalf of the applicant/client noted above, please complete this form with all relevant information. Once completed, **please fax: 1) completed certification form, 2) laboratory results, and 3) medication list to Community Servings, Client Services at 617-522-7770.** The certification form and laboratory results help us assess client eligibility, and the medication list helps our Registered Dietitian assess appropriate diet. Thank you for your help in serving our clients!

Applicant/Client: Height: _____ ft. _____ in. Weight: _____

A. PRIMARY DIAGNOSIS: Check all that apply.

- | | |
|--|--|
| <input type="checkbox"/> HIV+ | <input type="checkbox"/> Lung Disease |
| <input type="checkbox"/> AIDS (CDC defined) Year of diagnosis: _____ | <input type="checkbox"/> Cardiac Disease |
| <input type="checkbox"/> Cancer specify type: _____ | <input type="checkbox"/> Multiple Sclerosis |
| <input type="checkbox"/> Renal Disease | <input type="checkbox"/> Other – Please specify: _____ |
| <input type="checkbox"/> Diabetes: I or II (circle one) | |

B. MEDICAL CONDITIONS RELATED TO ILLNESS: Patient exhibited the following conditions in the past 30 days:

- End of life care – Please describe: _____
- Severe diarrhea, nausea, or vomiting (circle ones applicable)
- Oral or esophageal lesions preventing adequate nutritional intake
- Peripheral neuropathy significantly limiting standing and/or ambulation
- Anemia or other condition causing severe fatigue or shortness of breath
- Wasting (unintentional weight loss of more than 5% usual body weight)
- An opportunistic infection, neoplasm, or dementia (circle ones applicable) Describe: _____
- Chemotherapy or radiation therapy (circle ones applicable) Frequency of treatment: _____
- Mental Illness – Please describe: _____
- Other – Please describe: _____

C. MOBILITY: Factors that would impact a client's ability to maintain a healthy diet & independent lifestyle.

- Bed bound
- Can't stand for more than 15 minutes at one time.
- Can't walk more than 50 feet at one time.
- Can't carry a weight of more than 15 lbs.
- No cooking facilities
- Other _____

My signature certifies the medical information provide above.

Physician/NP/PA Signature

Clinic or Hospital Affiliation

Date

Print or Stamp Name

Telephone Number