



PROJECT OPEN HAND

730 Polk Street
1921 San Pablo Avenue

San Francisco, CA 94109
Oakland, CA 94612

415/447-2326 Fax: 415/447-2492
510/622-0221 Fax: 510/452-1061

Client Name: _____

Date of birth: _____

CLIENT CONSENT TO RELEASE INFORMATION

All certificates are subject to verification. Fraudulent documentation may lead to termination of services.

I authorize my medical provider to release information about my medical condition to Project Open Hand for purposes of verifying my eligibility.

Client Signature: _____

Date: _____

PROVIDER VERIFICATION OF STATUS

Symptoms/Conditions (Check all that apply):

Diarrhea	<input type="checkbox"/>	mild	<input type="checkbox"/>	severe
Mental Confusion/Dementia	<input type="checkbox"/>	mild	<input type="checkbox"/>	severe
Neuropathy	<input type="checkbox"/>	mild	<input type="checkbox"/>	severe
Fatigue/Weakness	<input type="checkbox"/>	mild	<input type="checkbox"/>	severe
Anemia	<input type="checkbox"/>	mild	<input type="checkbox"/>	severe
Wasting (unintentional weight loss of >5% or >10% of usual body weight) ..	<input type="checkbox"/>	mild	<input type="checkbox"/>	severe
Malignancy, undergoing treatment	<input type="checkbox"/>	yes		
Other Disabling Conditions (please specify) 1) _____	<input type="checkbox"/>	mild	<input type="checkbox"/>	severe
2) _____	<input type="checkbox"/>	mild	<input type="checkbox"/>	severe

Extenuating Circumstances (Check all that apply):

Severe Mental Illness
 Recent Incarceration (>1 year)
 Recent Immigrant
 Pregnant
 Active Substance Abuse
 Adolescent (13-25 years old)
 Currently Homeless

How will this nutrition service enhance your overall treatment plan? Check all that apply:

Enable client to comply with medication regimen
 Provide Medical Nutrition Therapy for Client
 Help manage chronic condition
 Ensure adequate access to nutrition
 Other (please specify): _____
 Prevent further deterioration of health

* RE-CERTIFICATION IS REQUIRED AT REGULAR INTERVALS *

My signature certifies that I am the Primary Medical Provider for the above named client, who:

- is **HIV positive**; and
- has the indicated conditions/symptoms and/or extenuating circumstances.

Signature of Physician/Nurse Practitioner/PA/RN

Phone & Fax Number

Date

Office stamp or address required here

Printed Name of Provider