REFERRED BY: _____ **PHONE:** _____ **FAX:** _____

730 Polk Street, San Francisco, CA 94109 T: 415-447-2326 F: 415-429-3852
1921 San Pablo Avenue, Oakland, CA 94612 T: 510-622-0221 F: 510-452-1061

Project Open Hand
meals with love

APPLICATION FOR SERVICES (6 month duration; subject to eligibility)

1. Consent to release information:

I authorize my medical providers/referring party to release information about my medical condition to Project Open Hand for the purposes of verifying my eligibility. I also authorize Project Open Hand to discuss the terms of my eligibility and/or services with my medical providers and referring party.

Patient Name: _____ Date of Birth: _____ Phone: _____

Patient Signature: _____ Date: _____ County: _____

Healthcare Provider only below this line

2. PHYSICAL DATA: (Must be current within six months)

Height: _____ ft _____ in. Current weight: _____ lbs Usual weight: _____ lbs (if applicable)

3. PRIMARY DIAGNOSIS and CLINICAL DATA: (Data must be current within six months; check all that apply)

- ☐ HIV+/AIDS
- ☐ Stage 3 Cancer; Type: _____
  Date of most recent diagnosis: _____
  Chemotherapy/Radiation? _____Y _____N
- ☐ Stage 4 Cancer; Type: _____
  Date of most recent diagnosis: _____
  Chemotherapy/Radiation? _____Y _____N
- ☐ Diabetes, Type 1; HbA1c: _____ Date: _____
- ☐ Diabetes, Type 2; HbA1c: _____ Date: _____
- ☐ End Stage Renal Disease (ESRD)
  eGFR: _____ mL/min/1.73 m^2 Date: _____
- ☐ Chronic Obstructive Pulmonary Disease (COPD)
  Stage: _____ FEV1: _____ Date: _____
- ☐ Congestive Heart Failure (CHF)
  NHYA Class: _____
- ☐ Coronary Artery Disease
  Total Cholesterol: _____ HDL/LDL: _____/_____
  Triglycerides: _____ Date: _____
- ☐ Hepatitis C
- ☐ Trauma/Major Surgery, within 30 days of discharge (6 week service)
  Type: _____ Discharge Date: _____

4. CONCOMITANT DIAGNOSES: (Check any exhibited in the past 30 days)

☐ Anemia ☐ Hypertension ☐ Hyperlipidemia

☐ Opportunistic Infection, inhibiting ability to access and/or prepare meals; describe: _____

5. SYMPTOMS: (Check any exhibited in the past 30 days)

☐ No Symptoms

☐ Chronic Intractable Diarrhea ☐ Chronic Nausea ☐ Chronic Vomiting

☐ Unintentional weight loss of more than 5% of baseline body weight in 1 month or 10% in 6 months

☐ Inability to gain weight if underweight (BMI < 18.5)

☐ Oral conditions preventing adequate nutritional intake

☐ Muscle weakness in one or more of the following areas: hands, arms or legs, or the muscles of speech or breathing

☐ Difficulty standing/ambulation due to: ☐ Twitching ☐ Numbness ☐ Tingling ☐ Muscle cramping

☐ Edema, or other severe swelling in ankles or feet

☐ Difficulty swallowing (dysphagia)

☐ Mild Fatigue ☐ Moderate Fatigue ☐ Severe Fatigue

☐ Mild shortness of breath ☐ Moderate shortness of breath ☐ Severe shortness of breath

☐ Mild diarrhea ☐ Mild wasting ☐ Severe pain ☐ Lymphedema

☐ Spasticity ☐ Ataxia ☐ Slow healing sores

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PATIENT NAME (PAGE 2) _____

6. OTHER FACTORS: (Check any exhibited in the past 30 days)

- ☐ Dementia
- ☐ Hospice or Palliative care
- ☐ Homeless or marginally housed
- ☐ Substance use – Describe: _____
- ☐ Mental illness – DSM V Diagnosis: _____
- ☐ Cognitive Deficit – Describe: _____
- ☐ Developmental Disability – Describe: _____

7. DELIVERY SERVICES: (Available to clients with restricted mobility residing in San Francisco and Oakland)

- ☐ **PATIENT IS ABLE TO PICK UP MEALS OR PATIENT HAS SUPPORT PERSON TO PICK UP MEALS**
- ☐ Bed Bound
- ☐ Unlikely able to stand for more than 15 minutes at a time
- ☐ Unlikely able to walk more than 50 feet at a time
- ☐ Unlikely able to carry a weight of more than 15 lbs.
- ☐ Likely to need physical or other assistance in leaving home
- ☐ Leaving home may create safety risk or hardship

8. LANGUAGE

Please list client's primary language: _____

9. NUTRITION SERVICES: (Available to all clients)

- ☐ Consult with patient's existing dietitian – Name: _____ Phone: _____

- ☐ Refer patient to Project Open Hand registered dietitian. If checked, please list or attach labs, relevant medical history, medications, surgeries, or other information not already included:

_____ _____ _____ _____

Provider Signature **Provider Printed Name & Title** **Office Stamp or Address, Phone, Fax** **Date**

(must be signed by licensed medical professional)