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

PROJECT OPEN HAND

730 Polk Street, San Francisco, CA 94109 415/447-2326 Fax: 415/447-2492
1921 San Pablo Avenue, Oakland, CA 94612 510/622-0221 Fax: 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 and referring party to release information about my medical condition to Project Open Hand for 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. Usual weight: _____ lbs. Blood pressure:_____/_____

Current weight:_____ lbs. Weight change over:_____ months Date: _____

3a. PRIMARY DIAGNOSIS and CLINICAL DATA: *(Check all that apply; data must be current within six months)*

☐ **NO PRIMARY DIAGNOSIS**

☐ **HIV+/AIDS**

☐ **Cancer, active diagnosis**

Type:_____ Stage: I II III IV *(circle one)*

Date of most recent diagnosis:_____

Active Treatments: *(circle those that apply)*

- Radiation therapy - Chemotherapy
- Hormone therapy - Not receiving treatment

☐ **Diabetes**

Type 1 or Type 2 *(circle one)*

HbA1c: _____ Date: _____

☐ **End stage Renal Disease (ESRD)**

Creatinine:_____ BUN:_____ Date:_____

☐ **End Stage Liver Disease (ESLD)**

☐ **Cardiovascular disease** *(circle those that apply)*

- Congestive Heart Failure (CHF) - NYHA Class: I II III IV *(circle one)*
- Coronary Artery Disease

Total cholesterol:_____ HDL / LDL:_____ / _____

Triglycerides: _____ Date: _____

☐ **Chronic Obstructive Pulmonary Disease (COPD)**

Stage:_____ FEV1:_____ Date:_____

☐ **Autoimmune disease (e.g. Lupus)**

☐ **Hepatitis B, chronic** or **Hepatitis C** *(circle those that apply)*

☐ **Serious Neurologic Condition** *(circle those that apply)*

- Stroke - Parkinson's
- Multiple Sclerosis - ALS (Lou Gehrig's disease)

☐ **Trauma/major surgery**, within 30 days of discharge *(6 week service)*

Type:_____ Discharge date:_____

3b. CONCOMITANT DIAGNOSES: *(Check any exhibited in the past 30 days)*

☐ **Opportunistic infection**, inhibiting ability to access and/or prepare meals - Describe:_____

☐ **Anemia** ☐ **Hypertension** ☐ **Hyperlipidemia**

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

☐ **NO SYMPTOMS**

☐ Chronic (>30 days), inhibits normal daily functioning: ***(circle those that apply)*** - Intractable diarrhea - Nausea - 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: ***(circle those that apply)*** - Hands, arms or legs - The muscles of speech or breathing

☐ Difficulty standing and/or ambulation due to: ***(circle those that apply)*** - Twitching (fasciculation) - Numbness - Tingling - Cramping of muscles

☐ Edema, or other severe swelling in ankles or feet

☐ Difficulty swallowing (dysphagia)

☐ Fatigue: ***(circle one)*** - Mild - Moderate -Severe

☐ Shortness of breath at rest: ***(circle one)*** - Mild - Moderate -Severe

☐ Mild diarrhea ☐ Mild wasting ☐ Severe pain ☐ Lymphedema ☐ Spasticity ☐ Ataxia ☐ Slow-healing sores

Signature of Provider	**Printed Name of Provider**	**Office Stamp**	**Address, Phone and Fax**	**Date**

V061715

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5. 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: _____

6. DELIVERY SERVICES: *(Available to clients with restricted mobility)*

☐ **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
☐ Requires 24hrs/day oxygen to treat lung or heart disease
☐ Requires someone to help patient prepare/cook food
☐ Leaving home may create safety risk or hardship

7. NUTRITION SERVICES: *(Available to all clients)*

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

☐ **Refer patient to Project Open Hand registered dietitian**: *(list labs, relevant medical history, medications, surgeries, or other information)*