Community Servings
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. The certification form, laboratory results and medications list help us determine client eligibility and an appropriate diet. Thank you for your help in serving our clients!

Please Fax the following to Client Services at 617-522-7770

- ❑ **Completed Certification Form**
- ❑ **Recent laboratory results (within past 6 months)**
- ❑ **Current medication list**

Applicant/Client: Height: _____ft. _____in. Weight: _____

A. PRIMARY DIAGNOSIS: Check all that apply.

- ❑ AIDS (CDC defined)
  Year of diagnosis: _____ (Required)
- ❑ HIV+
- ❑ Cancer (specify type): _____
  □ Chemotherapy/Radiation Therapy
- ❑ Cardiac Disease (specify type):_____
- ❑ Diabetes: I or II (circle one)**provide A1c result**
- ❑ Lung Disease
- ❑ Multiple Sclerosis (no labs required)
- ❑ Renal Disease (Stage if known) _____
  □ Dialysis
- ❑ Other – Please specify:
  _____

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

- ❑ End of life care (no labs required) – Please describe: _____
- ❑ Severe diarrhea, nausea, or vomiting (**circle ones applicable**)
- ❑ Oral or esophageal lesions preventing adequate nutritional intake (**circle ones applicable**)
- ❑ 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: _____
- ❑ 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.
- ❑ Other_____

My signature certifies the medical information provided above.

_____ _____ _____

Physician/NP/PA Signature Clinic or Hospital Affiliation Date

_____ _____

Print or Stamp Name Telephone Number