Please submit by:	THIS INFORMATION IS CONFIDENTIAL	Date submitted:

Certification for Medical Meals must be completed by Healthcare Provider and returned to Open Hand Client Services at: Phone: 404-872-6947 Fax: 770-234-3898

Patient Name:_____

Address:_____

Phone Number: _____ **Email:** _____

Date of Birth: _____ **SS #** _____- _____ - _____
(mm/dd/year)

Date of Last Medical Appointment:_____
(within 6 months)

I certify that this patient is under my care for the following:

☐ AIDS or HIV diagnosis CD4: _____ Viral Load: _____

AND one or more of the following nutrition-related problems:
(Prepared meals for 6 months, with 6-month reassessment required)

☐ Inadequate intake and/or poor absorption of nutrients due to medical condition

☐ AIDS wasting syndrome or lipodystrophy

☐ Unintentional weight loss ≥ 5% in past 6 months

☐ Altered nutrient metabolism due to:

☐ CKD (GFR < 60 mL/min./1.73m^2) ☐ Uncontrolled diabetes (A1C ≥ 8%)

☐ Hyperlipidemia (LDL ≥130 mg/dL; TG ≥ 150 mg/dL)

OR

☐ Patient requires palliative or end-of-life care
(Prepared meals for 3 months, with 3-month reassessment required)

☐ Severely restricted in ADLs such that patient is unable to shop for food and prepare meals
(Prepared meals for 3 months, with 3-month reassessment required)

☐ Restricted in ADLs such that patient is unable to shop for food but is able to prepare meals
(Pantry program for ☐ 3 months *or* ☐ 6 months, with 3-month / 6-month reassessment required)

OR

☐ Patient's health has improved and he/she no longer requires meals and/or pantry support

☐ Patient to participate in nutrition education and on-going coaching as part of his/her disease self-management program

☐ Patient to be referred to clinic registered dietitian for Medical Nutrition Therapy (MNT)

Medical Provider: (*name and title*) _____

Medical Provider Signature: _____

Health Care Agency or Facility: _____

Address:_____

Phone: _____ **Fax:** _____

Client Release

Client Signature: _____ **Date:** _____

By signing above, I give permission for the release of my medical information specifically for the purposes of receiving nutrition-related services from Open Hand/Atlanta. I understand that my signature will be required every 3 months or 6 months, as indicated above by my medical provider, for recertification. **I also commit to staying actively involved in my own health and disease management.**