Send completed form to, and reach us, at:

Client Services - Project Angel Food
922 Vine Street
Los Angeles, CA 90038
Phone: (323) 845-1810
Fax: (323) 845-1834

MEDICAL RECERTIFICATION (HEALTH CARE PROVIDER)

GENERAL INFORMATION

For clients who are applying to continue receiving meals from PAF, we require this form to be completed by their health care provider and returned to PAF as soon as possible.

Patient Name_____ Date of Birth_____

Height_____ft _____in Weight:_____lbs BMI_____ %IBW_____ Blood Pressure_____

Cholesterol_____ HDL/LDL_____/_____ Triglycerides_____ Date of labs_____

Food allergies_____ Severity of Reaction _____

Note: The patient will not be eligible if they have a life-threatening allergy.

Is assistance needed with feeding? ☐Yes ☐No

Meal Plan: ☐Heart Healthy ☐Dialysis Friendly ☐Low Protein
☐Diabetic ☐Vegetarian ☐Low Fiber / Low Acid

Are there any other special diet instructions (e.g., no pork, no lactose, chopped texture)? We will review and apprise the client if we can honor._____

Are there any mobility restrictions (e.g., bedbound, wheelchair, walker, cane, Medi-Access, loss of limb, loss of sensory ability)?_____

Have there been 2 or more E.R. visits / surgeries / hospitalizations in the previous 12 months? ☐Yes ☐No

*If yes, explain*_____

Is life expectancy estimated to be six months or less? ☐Yes ☐No

SPECIFIC QUALIFYING MEDICAL CONDITION INFORMATION

HIV/AIDS

☐HIV positive ☐AIDS

Viral Load_____ CD4_____ Date of labs_____

On medication and medically adherent? ☐Yes ☐No

Effects on current health and well-being?_____

Cancer

Type_____ Stage_____ Alb_____ Lab date_____

Chemotherapy, radiation, or other current treatment_____

Kidney or Liver Disease

☐End stage renal disease

Dialysis center_____ Dialysis Treatment Began ___/___/___ Dialysis Day(s) _____

☐Chronic kidney disease

Stage_____ Date of labs_____

Creatinine_____ eGFR_____ Hgb_____ Phosphorus_____

Potassium_____ Bun_____ Alb_____

☐Liver cirrhosis
Severity_____
☐Hepatitis C

Lung Disease (non-cancerous)
☐COPD ☐Asthma ☐Other_____

Oxygen assistance? ☐Yes ☐No If yes, is 24-hour oxygen assistance required? ☐Yes ☐No

Other information regarding severity_____

Heart Disease
☐Congestive Heart Failure
ICD-10 code_____ NY Class (if known)_____ Ejection fraction____ Date of labs_____

Describe severity_____
☐Stroke
Date(s)_____

Describe severity_____
☐Heart attack
Date(s)_____

Describe severity_____

Diabetes
☐Type 1 ☐Type 2

☐Controlled ☐Uncontrolled

A1c_____ Blood glucose_____ Date of labs_____ On Insulin? ☐Yes ☐No

Other known effects on health (e.g., sight or use of limbs)?_____

Neurological Conditions
☐Alzheimer's ☐Dementia ☐Neuropathy ☐MS ☐Other_____

Describe severity_____

Muscular-Skeletal Conditions
☐Parkinson's ☐ALS ☐Other_____

Describe severity_____

Other Condition(s) Not Listed Above

_____

Is there anything else we should know about this patient's medical condition or situation to help us in evaluating the patient for service?_____

_____

VERIFICATION

Provider's name_____ Signature_____

Medical Office _____

Phone_____ Fax_____ Date_____