SPECIAL DELIVERY
SAN DIEGO

ELIGIBILITY FOR HOME DELIVERED MEALS

I, _____ authorize _____
(Name of patient) (Name of clinic)
to email the below completed from to Special Delivery San Diego (rhenricks@aol.com).

Signature of patient

This is to certify that _____ is being treated at
Name of patient

_____ by _____
Name of clinic Name of physician

_____ Symptomatic HIV disease _____ AIDS and would benefit from receiving Home delivered meals.

Please check all current symptoms.

_____ Severe weight loss ____ Chronic diarrhea _____ CMV colitis

_____ Gastroenterpothy _____ Wasting Syndrome ____ Fat malabsorption

_____ Protein/Caloric Malnutrition _____ Enteropothy _____ Lactose intolerant

Other symptoms: _____

_____ _____
Signature of Physician or Case Manager Date

Please complete this form and return to us at the address below or email it to us.

4021 Goldfinch Street • San Diego CA 92103
619-297-7373 *phone* • 619-297-7632 *fax* • specialdeliverysd@hotmail.com *email* • www.SpecialDeliverySanDiego.com *website*