COMMUNITY SERVICES
Senior Services

Print Form

PHYSICIANS CERTIFICATE OF NEED

TO:

PHYSICIAN _____

PHYSICIAN'S PHONE _____

PHYSICIAN'S FAX/EMAIL _____

FROM: IRVINE MEALS ON WHEELS; Phone: 949-724-6910; Fax: 949-724-6925; Email: channa@cityofirvine.org

REGARDING:

PATIENT _____

DATE OF BIRTH _____

ADDRESS _____

Your patient has requested home delivered meals from Irvine Meals on Wheels. Program eligibility for home delivered meals requires that participants:

1. Must be age 60 or over;
2. Reside in the City of Irvine;
3. Be homebound (not driving) due to illness or disability;
4. Are unable to prepare his/her own food and has no one to do this for them; and
5. **Do not have any dietary restrictions or allergies, other than limited sodium, sugar and fat content.***

*** Irvine Meals on Wheels contain: <1000 mg of Sodium per meal (<2300 mg per 3 meals), < 10% Saturated Fat**

I certify that the above patient qualifies for Irvine Meals on Wheels.

PHYSICIAN'S SIGNATURE _____ DATE _____

Please fax or email completed form to Irvine Meals on Wheels at 949-724-6925 or channa@cityofirvine.org so that we may complete the evaluation process.

PARTICIPANT STATEMENT

I, _____, have given permission for Irvine Meals on Wheels to contact my physician regarding my functional and dietary needs.

PARTICIPANT'S SIGNATURE _____ DATE _____