Print Name: _____

ASSISTANCE DOG APPLICATION
Part two

Professional Reference Report

THIS SECTION IS TO BE COMPLETED BY YOUR PHYSICIAN

Print Patient's Name: _____

Doctor's Name: _____

Doctor's Address: _____

City: _____ State: _____ Zip: _____

Date of last visit: _____

How long have you been associated with this patient? _____

Please give prognosis and list the effects of your patient's disability relating to the individual's ability to engage in activities of daily living (ADL). These include the ability to attend to personal care needs such as feeding, toileting, dressing, managing finances, maintaining home, and attaining needed outside services.

Patient suffers from or is being treated for the following:

☐ Traumatic Brain Injury (TBI)	☐ Post-traumatic Stress Disorder (PTSD)	☐ Seizures
☐ Anxiety and/or Depression	☐ Spinal Cord or Disc Injury	☐ Diabetes
☐ Multiple Sclerosis	☐ Disequilibrium or Balance Issues	☐ Arthritis
☐ Muscular Dystrophy	☐ Post-polio Syndrome	☐ Cerebral Palsy
☐ Bi-polar Disorder	☐ Loss of limb	

Other: _____

_____

_____

_____

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Print Name: _____

Mental/ Emotional Evaluation of Patient:

1. Does your patient have the ability to exercise judgment and make decisions necessary for ADL? ☐ Yes ☐ No
2. Does your patient possess the ability of memory and perception necessary for ADL?
   ☐ Yes ☐ No ☐ Minimally
3. Does your patient have the ability to sustain a reasonable attention span?
   ☐ Yes ☐ No
4. Is your patient taking any medications in which it impairs normal functioning?
   ☐ Yes ☐ No

   If yes, what?

_____

_____

_____

_____

_____

5. Does your patient demonstrate inappropriate behavior that is beyond his/her control?
   ☐ Yes ☐ No ☐ Minimally

   If yes, please explain:

_____

_____

_____

_____

6. Does your patient possess the ability to learn and follow directions to the degree necessary to sustain ADL? ☐ Yes ☐ No ☐ Minimally

7. Is your patient able to make decisions concerning his/herself as well as others' needs and safety? ☐ Yes ☐ No ☐ Minimally

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8. Is your patient's disability due to or affected by alcoholism, drug use or abuse?
   ☐ Yes ☐ No

   If yes, please complete the following:

   1. Has your patient ever been accepted into a treatment facility?
      ☐ Yes ☐ No

   If yes, when: _____

   b) Has your patient ever refused treatment or a referral to a treatment center?
      ☐ Yes ☐ No

   c) Is your patient capable of making rational decisions?
      ☐ Yes ☐ No

   d) Does your patient present a danger to him/herself or others?
      ☐ Yes ☐ No

9. Do you recommend this patient for an assistance dog?
   ☐ Yes ☐ No

10. May we contact you for more information or clarification?
    ☐ Yes ☐ No

11. Additional Comments:

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____ _____

Signature of Professional Date

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MEDICAL HISTORY REPORT

Current Physical Status:

1. Visual Impairment: ☐ Yes ☐ No

   If yes, please describe:

_____

_____

Uncorrected Vision: Right:_____ Left:_____

Corrected Vision: Right:_____ Left: _____

_____

2. Hearing Impairment: ☐ Yes ☐ No

   Right:_____ Left:_____

   If yes, please describe:

_____

_____

3. Speech Impairment: ☐ Yes ☐ No

   If yes, please describe:

_____

4. Cardiac System Involvement: ☐ Yes ☐ No

   If yes, please describe in detail. Include such information as use of pacemaker, monitor, arrhythmias, murmurs, history of cardiac arrest or congestive heart failure, circulation deficiencies, etc.:

_____

_____

_____

5. Renal system involvement: ☐ Yes ☐ No

   If yes, please describe in detail, including whether patient requires dialysis, type of dialysis, and frequency:

_____

_____

_____

_____

_____

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Use of Catheter ☐ Yes ☐ No

If yes, is it ☐ Suprapubic or ☐ Indwelling

6. Respiratory system involvement: ☐ Yes ☐ No

   If yes, please describe in detail, including history of respiratory arrest or insufficiency:

7. Seizures: ☐ Yes ☐ No

   If yes, please describe, including cause (if known) type, frequency of occurrence, duration, and integral since last seizure:

8. Learning Disabilities: ☐ Yes ☐ No

   If yes, please describe:

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9. Mental and Emotional status.

Does patient exhibit any of the following?

Awareness of surroundings:	☐ Yes	☐ No
Appropriate orientation:	☐ Yes	☐ No
Appropriate attention span:	☐ Yes	☐ No
Ability to relate positively with others:	☐ Yes	☐ No
Ability to communicate ideas clearly:	☐ Yes	☐ No
Ability to follow, absorb & incorporate sequenced instructions:	☐ Yes	☐ No
Ability to form insights, judgments and to plan course of action:	☐ Yes	☐ No

If there are any "No" answers to Question above, please explain.

_____

_____

_____

10. Mental and Emotional Status.

Memory Impairment:	☐ Yes	☐ No
Prior history of institutionalization:	☐ Yes	☐ No
History of substance abuse:	☐ Yes	☐ No

If there are any "Yes" answers to Question above, please explain:

_____

_____

_____

11. Medications:

Please list all medications currently prescribed, dosage, conditions requiring medications and anticipated response to the medication. Please, also indicate possible side effects:

_____

_____

_____

_____

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Restrictions and Recommendations for Patient during Team Training:

Team Training involves a minimum of two weeks of intensive training. A significant amount of physical exertion is required of the participant while learning the skills necessary to using an assistance dog. As training progresses, participants are required to make trips to local malls and other locations, these outings involve typical ADL and are necessary for the participant to learn to use his/her dog in public.

While Team Training is physically and emotionally demanding, the support a dog will provide after placement greatly reduces the amount of energy the recipient must expend each day. Time, effort, and emotional commitment are necessary to the formation of successful recipient/assistance dog team.

Please list any restrictions you feel should apply to this patient during Team Training:

_____

_____

_____

_____

PHYSICIAN'S STATEMENT:

It is my opinion that this patient is physically, mentally, and emotionally able to participate in Team Training for an assistance dog. I believe that such a placement would contribute to his/her independence.

_____ _____

Physician's Signature Date

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