



Print Name: _____

**ASSISTANCE DOG APPLICATION
Part two**

Professional Reference Report

THIS SECTION IS TO BE COMPLETED BY YOUR HEALTHCARE PROVIDER

Print Patient's Name: _____

Provider's Name: _____

Provider'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:

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

Other:



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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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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 that may impact the person's ability to participate in team training. Please list 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:

PROVIDER'S STATEMENT:

I attest that this patient is capable of caring for a dog and participating in handler training, including required travel if appropriate. 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.

Provider's Signature

Date