Applicant Medical History Form

This form is to be completed by your physician and sent directly to Canine Assistants via email to theresa.martin@canineassistants.org or fax to 770-664-7820.

Information Release:

Dr. _____,
Please release the requested medical information regarding my condition to the above identified organization. This information will be used to help determine my abilities in regards to the placement of an assistance dog.

Applicant's Name (please print):_____

Applicant's Signature:_____
Date:_____

Doctor's Name:_____

Type of practice: _____

Address:_____

City:_____ County:_____ State:_____ Zip:_____

Phone:_____
Fax:_____

Patient Information:

What is this patient's primary disability?_____

What is the cause of this disability?_____

Are there significant secondary disabilities?_____( ) Yes ( ) No

If yes, please describe: _____

At what age was he/she disabled?_____ Is this disability progressive? ( ) Yes ( ) No

Is there an incapacity due to alcohol or drug abuse?_____( ) Yes ( ) No

Does the patient smoke?_____( )Yes ( )No

PLEASE CIRCLE ALL THAT APPLY:

This effects of this patient's disability include:

Deafness Speech impairment Reduced stamina Hearing loss

Coordination problems Limited mobility Memory loss Spasticity

Delayed development Vision impairment Muscular weakness

*Other:*_____

Does this patient have trouble with...

Allergies Chronic pain Heightened emotions Depression

Seizures Balance Brittle bones Heat/Cold Sensitivity

Does this patient use any of the following aids or assistive devices?

Prosthesis Leg brace Wheelchair- manual Wheelchair- electric

Wrist brace Hearing aid Crutch/cane Walker

*Other:*_____

Does this patient...

Drive Travel by bus Travel by airplane

Current number of hours of attendant care per week:_____

ADL= Activities of Daily Living

Is this patient:	Please Circle Below
A. Able to exercise judgment and make decisions necessary for ADL?	Yes Minimally No
B. Able to sustain an attention span?	Yes Minimally No
C. Manifesting inappropriate behavior beyond his or her control?	Yes Minimally No
D. Able to control physical and motor movement sufficient to sustain ADL?	Yes Minimally No

E. Capable of perception and memory to the degree necessary to sustain ADL? Yes Minimally No

F. Able to follow directions and learn to the degree necessary to sustain ADL? Yes Minimally No

G. Under medication which impairs physical or mental functioning? Yes Minimally No

H. Capable of decisions concerning self and others needs and safety? Yes Minimally No

Can you recommend this individual for an assistance dog?_____( ) Yes ( ) No

Comments: _____

_____

_____

Do you feel Canine Assistants needs to speak with you about this applicant? ( ) Yes ( ) No

Physician Signature:_____ Date:_____