Applicant Medical History Form

This form is to be completed by your physician and sent directly to Canine Assistants via email to nicole.hern@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 needs and eligibility in regards to placement of an assistance dog.

Applicant's Name (please print):_____

Applicants 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? _____

If yes, please describe: _____

At what age was he/she disabled? Is this disability progressive?_____

Does the patient smoke? _____

PLEASE CIRCLE ALL THAT APPLY:

The 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 Anxiety
Seizures	Balance	Brittle Bones	Heat/Cold Sensitivity

Does this patient use any of the following 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:

A. Able to exercise judgement and made decisions necessary for ADL?	Yes	Minimally	No
B. Able to sustain an attentions 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 for perception and memory to the degree necessary to sustain ADL?	Yes	Minimally	No
F. Able to follow directions and learn to the degree necessary for 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

Current Medications _____

_____

_____

Service dogs can run into difficulties and create problems for the team if the patient does not use the dog appropriately and according to the law.

Would you expect that he/she:

[ ] The capacity to bathe, toilet, groom, provide proper nutrition, exercise and ensure proper veterinarian care for the dog?

[ ] The capacity to meet the service dog's social and emotional needs throughout the dog's life?

[ ] The ability, motivation and acceptance of the responsibility for using the dog appropriately?

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

Comments:_____

_____

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

Has this individual been fully vaccinated for COVID-19? ( ) Yes ( ) No

Booster? ( ) Yes ( ) No

If no, do you recommend this person be vaccinated for COVID-19? ( ) Yes ( ) No

If no, please explain _____

_____

Physical Signature: _____ Date:_____