Guide Dogs of the Desert
PO Box 1692, Palm Springs, CA 92263
Phone: 760-329-6257 Fax: 760-329-2866
Email: admissions@gddca.org

INFORMATION RELEASE FORM

I, ____, hereby give my consent and authorization to release information from the physicians, agencies and guide dog schools listed in my application, for the purposes of determining eligibility for a guide dog training program, to assist in providing appropriate medical attention, and for any other legal purpose deemed necessary by Guide Dogs of the Desert.

____
Applicant Signature Date

____
Applicant Printed Name Date

A copy of this form will be sent to each physician, medical agency, and guide dog school.

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PHYSICIAN'S REPORT

Applicant: This form must be completed by your primary physician upon an examination.

Physician: Your patient has applied for a guide dog to enhance his/her mobility and independence. When completing this form, Please keep in mind that the applicant will undergo rigorous training, both physical and mental. They will spend 28 days training and will be expected to walk a minimum of ½ hour twice daily in all types of terrain, with their guide dog regardless of weather conditions. Your information will help us provide your patient with the training and instruction most suited to their needs.

The Ophthalmologist's report and verification of blindness is a separate form.
Thank you for your assistance.

Applicant's Name: ____
Date of birth:____
Address, City, State, Zip Code:____
Home Telephone______________________________Mobile Telephone____________________

Medical/Clinic ID number:______________________________Height: _______Weight: _______

Blood Pressure: _______ Pulse: _______ Respirations _______

How long have you attended to the applicant?____
Date of last tetanus immunization?____
Is application legally blind? Yes ___No___ If yes, cause of blindness________________________

Does the applicant have any of the following medical problems. Please answer yes or no.

Applicant Name___________________________ Physician's Report - Page 2

Arthritis	Allergies	Asthma
Cancer	Circulatory	Back
Amputations	Addictions	High Blood Pressure
Seizures	Heart Disorder	Knee/Hip
Psychiatric	Epilepsy	Intestinal
Ulcers	Headaches	Foot
Infectious Disease	Fainting	Neuropathy
Dexterity	Nervousness	Speech Impairments
Please explain a "yes" to any of the above (use a separate piece of paper if necessary).		

Please list any allergies____

____

Does the applicant have any hearing loss?________ Which ear? R L Both

Does the applicant wear hearing aids?____

Is hearing within normal range with aids?____

Does applicant have a learning disorder?____

Does applicant have any impairments of the use of either

Leg or foot?________________________________Hand/Arm____________________________

Is the applicant diabetic?________________If yes, please complete diabetic report.

Is applicant stable enough to undergo the rigors of training away from home for 28 days?__________
If no, please explain on back side.

___________________________________ ___________________________________

Physician's Signature and Date Physician's name (please print)

Telephone___________________________ Place Clinic/Hospital Stamp Here

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DIABETIC REPORT

Physician and applicant: Guide Dogs of the Desert does not have a nurse on staff. Applicant must be capable of administering his/her own injections and must be responsible for maintaining an appropriate lifestyle. Diabetic meals are available. Our protocol is to call 911, should the applicant need assistance.

Applicant Name____

Is Applicant Type I_______ Type II_______ Stable_______ Brittle _______

Last insulin reaction______________________________Please describe ___________________

____

Are insulin reactions frequent?_________________________Severe______________________

What can be offered in the event of a reaction?____

Date of last hospitalization due to

Hypoglycemia________________Hyperglycemia______________Diet______________________

Oral Medication___________________________Daily Dosage____________________________

Insulin Name_____________________________Daily Dosage_____________________________

Does Applicant utilize an Insulin pump? Yes_______ No_______
If yes, special instructions____

Can Applicant self-administer and/or adjust their own insulin?______________________________

____

Please indicate any special instructions on backside of this form

I understand the protocol of Guide Dogs of the Desert and certify that the above information is true and correct.

____________________________________ ____________________________________
Physician's Signature | Physician's printed name (please print)

____________________________________ ____________________________________
Physician's phone number | Date

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MEDICATION AND HEALTH INSURANCE INFORMATION

Physician and Applicant: Please list all medications, strength, dosage, and reason for use. Also, please indicate any side effects that may affect the applicant during their time in training. Applicant is responsible for administering his/her own medication. Please ensure applicant has enough medication for the entire 28 day class.

Applicant's name ____

Medication	Strength	Dosage	Reason	Side Affects

Health Insurance Information

Policy Number____

Policyholder's Name____

Insurance Company____

Telephone Number____

Physician Name and contact information ____

____