P.O. Box 1692, Palm Springs, CA 92263
Phone: 760-329-6257 Fax: 760-329-2866
Email: admissions@gddca.org

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: ______________________
Telephone: (____) __________ Medical/Clinic ID number: ______________

Height: ______ Weight: ________ Blood Pressure: ________ Pulse: ________ Respiration: ______

How long have you attended the applicant? First visit ____ ; # of years ____ Date of last tetanus immunization: ______

Is applicant legally blind? ☐ Yes ☐ No **Cause of blindness**: ______________

Does the applicant have any of the following medical problems?

Arthritis ________	Allergies ________	Asthma ________	Cancer ________
Circulatory Problems ________	Back Problems ________	Amputations ________	Addictions ________
High Blood Pressure ________	Seizures ________	Heart Disorder ________	Knee/Hip ________
Psychiatric Problems ________	Epilepsy ________	Intestinal Problems ________	Ulcers ________
Headaches ________	Foot Trouble ________	Infectious Diseases ________	Fainting ________
Neuropathy ________	Dexterity Problems ________	Nervousness ________	Speech Impairments ________

If yes, please explain ______________________

____

Please list any surgeries ______________________

Does the applicant have a hearing problem? ________ **Which ear?** ☐ **Left** ☐ **Right** ☐ **Both**

Does applicant wear hearing aides? ________ Is hearing within normal range with aides? ________

Does applicant have a learning disorder? ______________________

Does applicant have any impairments of the use of either leg/foot? ________ **Hand/arm** ________

Does applicant have any limitations? Please explain ______________________

Is applicant diabetic? ________ **If yes please complete diabetic report.**

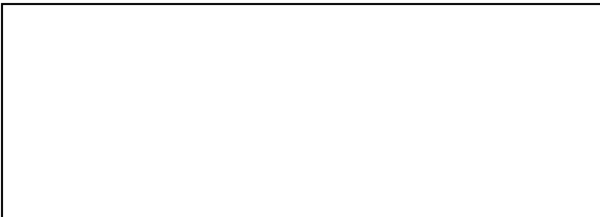
***Is applicant stable enough to undergo the rigors of training away from home for 28 days?** ________

Date of exam on which report is based: ________

____
Physician's Signature

Doctor's name: ______________________
Please print

Telephone: (____) ______________________



Hospital / Clinic Stamp

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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's name: ______________________________

Is Applicant: ☐ Type I ☐ Type II ☐ Stable ☐ Brittle

Last Insulin reaction: ____________________ please describe: ____________________

____

Are Insulin reactions frequent? ______________________________

Are Insulin reactions 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 please list any special instructions ______________________________

Can Applicant self-administer Insulin? __________ Can Applicant adjust his/her own Insulin? __________

Please indicate any special instructions or suggestions ______________________________

____

____

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

____________________ Physician's Signature	____________________ Applicant's Signature
____________________ please print name	____________________ please print name
__________ date	__________ 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 ____ **Date** ____________

Medication	Strength	Dosage	Reason	Side Effects

Health Insurance Information

Policy number: ____

Policyholder's name: ____

Insurance Company: ____

Telephone number: ____