This form must be completed by your primary care doctor soon after your physical examination. When completed, return it to Guide Dogs of The Desert to continue the processing your application.

Guide Dogs of the Desert

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

PHYSICIAN'S REPORT

Attention 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 a rigorous training program. This program will require physical, emotional and mental stability, as well as endurance and strength. Furthermore, the days will be long, as our training begins at 6:00 am and will not end until 9:00 pm. This in-residence program lasts for 28 days and will include exposure to different types of terrain and weather, including a windy, desert environment. Students attending this course must be reasonably independent with chronic disease management, and demonstrate normal immunity in a dormitory setting. Students are expected to walk at least a ½ - 1 hour twice daily, and will experience a definable pull from a dog (typically on the left side). Your information will assist us with determining if the applicant is eligible for a guide dog, and if they will be able to handle the rigors and stress of training. 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: _____

Does applicant have bilateral prosthetics? ☐ Yes ☐ No

Does the applicant have any of the following medical problems? (Please check all that apply)

Breathing: Allergies ☐ Asthma ☐ Lung capacity ☐

If so, please explain: _____

Circulatory: Cardiac disorders ☐ High blood pressure ☐ Varicose veins ☐

If so, please explain: _____

Disease: Infectious ☐ Chronic ☐ Cancer ☐ Skin Cancer ☐

If so, please explain: _____

Is applicant able to be in the sun? ☐ Yes ☐ No If no, please explain: _____

_____

Neurologic disorders: (neuropsychology): Speech impairment ☐ Stroke ☐ Seizures ☐

Epilepsy ☐ When was the last seizure? :

Frequent Headaches ☐ Migraines ☐ ☐ Yes ☐ No How often? _____

Psychiatric disorders: Anxiety ☐ Depression ☐ Addictions ☐ Other ☐

If so, please explain: _____

Is patient currently under the care of a mental health professional? ☐ Yes ☐ No

Physical: Balance ☐ Gait ☐ Posture ☐

If so, please explain: _____

Intestinal: Ulcers ☐ Diarrhea ☐ Gastric ☐

If so, please explain: _____

Pain: Is there weakness / pain on the left side? ☐ Yes ☐No

Note: Dogs are usually trained to walk/pull on the left side

Back problems ☐ Joint pain, arthritis ☐ Hip ☐ Knee ☐ Neuropathy ☐ Shoulder pain ☐

Arm pain ☐ Hand pain ☐ Chronic pain? ☐

If so, how does applicant deal with pain? _____

On a scale of 1—10, 10 being the most severe, please rate pain intensity.

_____

Please list any surgeries _____

Does applicant have hearing problem? _____ **Which ear? ☐ Left ☐ Right ☐ Both**

Does applicant wear hearing aides? _____Is hearing within normal range with aides? _____

Does applicant have a learning disability? _____

_____

Does applicant have any functional limitations besides blindness? ☐ Yes ☐ No

Please explain _____

Is applicant diabetic? _____ ☐ Yes ☐ No **If yes please complete diabetic report.**

Are there mental health issues? ☐ Yes ☐ No

Do you feel your patient will be able to complete our training program? ☐ Yes ☐ No **Do you have any additional thoughts or concerns**_____

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 their own appropriate lifestyle. The applicant will be asked to list dietary needs on their meal questionnaire, and we will respond the needs as best we can. As we do not have a nurse on staff, our protocol is to call 911, should the applicant need assistance.

Applicant's name: _____

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

Is applicant able to independently test their blood sugar?

Are they able to use an audio glucometer? How often do they test?

Last Insulin reaction: _____ please describe: _____

Are Insulin reactions frequent? _____

Are Insulin reactions severe?

Does insulin need to be refrigerated? _____

What can be offered in the event of a reaction?

Applicants should carry their own supplies when out training.

To the best of your knowledge, does your patient try to manage their own diabetes independently, and to the best of their ability? _____

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: _____