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.

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 ☐ Smoker ☐

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 Fall Risk

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

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

______________________________ Please print name

Date ________________

______________________________ Applicant's Signature

______________________________ Please print name

Date ________________

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: ____