



Applicant Medical History Form

This form is to be completed by your physician and sent by him/her directly back to New Life K9s. Please sign the release below before giving the form to your physician.

Dr. _____ Please release the requested information regarding my condition to New Life K9s. This information will help determine my abilities in regard to the placement of an assistance dog. Applicant's Name (please print) _____ Applicant's Signature _____ Date: _____ Phone Number: _____

DOCTOR'S NAME _____
Type of Practice _____
Street Address _____
City _____ State _____ Zip _____
Phone (____) _____ Fax (____) _____
Email _____

Yes, you may contact me for further information or clarification if needed.

PATIENT INFORMATION:

What is this patient's primary disability? _____

What was the cause of the disability? _____

At what age was (s)he disabled? _____ Is this disability progressive? _____

Are there additional disabilities such as mild TBI? (If so, please identify)

Current Medications _____

Current number of hours of attendant care per week: _____

For Post-traumatic stress applicants: Is there an active mental health treatment plan?

yes no

Would you recommend that a service dog be part of this patient's treatment plan?

yes no

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Please check each of the following using these number descriptions:
0=non-applicable 1=mild 2=moderate 3=severe

MOTOR IMPAIRMENTS -

Weakness Spasticity Coordination Other

SENSORY IMPAIRMENTS -

Vision Hearing Loss of sensation

COGNITIVE IMPAIRMENTS -

Attention Memory Problem solving Judgment

COMMUNICATION IMPAIRMENTS -

Comprehension Expression

PSYCHOLOGICAL / BEHAVIORAL DESCRIPTIONS -

- Depression Impaired Self-Esteem Hopeless / Helplessness
 Appetite Disturbance Suicidal Ideation Isolation
 Lack of Empathy Panic Attacks Hyper-vigilance
 Anxiety Emotional Numbness / Detachment / restricted Affect
 Sleep Disorder Nightmares / Flashbacks / Intrusive Thoughts
 Impulsivity Exaggerated Startle Response
 Irritability / Anger Control Issues
 Substance Abuse: If applicable, please describe in more detail type & severity:
-

ADDITIONAL MEDICAL CONDITIONS - (CHECK ANY THAT APPLY)

- Cardiovascular disease Respiratory disease Diabetes
 Neurogenic bladder Chronic pain Seizure disorder
 Neurogenic bowel Other: _____

ASSISTIVE DEVICES - (CHECK ANY THAT APPLY)

- Manual wheelchair Power wheelchair/scooter Walker
 Cane Crutches Orthosis Prosthesis Hearing aid

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Please identify Functional Independence Measure (FIM) levels for the following motor activities based on this scale:

No helper

- 7 Complete independence (timely, safely)
- 6 Modified independence (device)

Helper-modified independence

- 5 Supervision
- 4 Minimal assistance (you can perform 75% of activity)
- 3 Moderate assistance (you can perform 50% of activity)

Helper-complete dependence

- 2 Maximal assistance (you can perform 25% of activity)
- 1 Total assistance (you can perform 0% of activity)

Self-Care

- Eating Grooming Bathing Toileting
- Dressing-upper body Dressing-lower body

Sphincter Control

- Bladder management Bowel management

Transfers

- Chair, wheelchair Toilet Tub, shower

Locomotion

- Walk & Wheelchair Walk Wheelchair Stairs

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:

- Y / N The capacity to bathe, toilet, groom, provide proper nutrition, exercise and ensure proper veterinarian care for the dog?
- Y / N The capacity to meet the service dog's social and emotional needs throughout the dog's life?
- Y / N The ability, motivation and acceptance of the responsibility for using the dog appropriately?
- Y / N The financial means to travel for an interview in San Luis Obispo, at a later date to attend a two-week client training (tuition, housing, travel, food, entertainment, other expenses, etc.) in San Luis Obispo, and the annual cost (food, veterinarian care, flea treatment, supplies, other medicine as needed) for a dog?

If you are unable to recommend this individual for an assistance dog please indicate which of the following concerns apply:

- History of treatment resistance
- Consistent lack of insight regarding disability & related care needs
- Unstable home environment
- Unable to care for dog (either directly or with physical assistance of others)
- Potential for abuse of dog
- Potential for unsafe, unhealthy environment for dog

Please provide additional details if you checked any of the above items:

Can you recommend this individual for an assistance dog? _____

Do you have additional comments/concerns? if so, please explain:

Physician's Signature

Date



New Life K9s
PO Box 4412
San Luis Obispo, CA 93403
805-544-5433
www.NewLifeK9s.org

Client Reference — Service provider

Name: _____ Date: _____

Phone: (____) _____ Fax: (____) _____

I hereby give my permission for the above-stated service provider to supply any information regarding my physical and/or psychosocial status to New Life K9s for the purpose of completing my application for an assistance (service) dog.

Client Name (Please print clearly)

Client Signature

Service Provider Contact Information

Name: _____

Relationship: _____ Phone: (____) _____

Fax: (____) _____

Name: _____

Relationship: _____ Phone: (____) _____

Fax: (____) _____

Name: _____

Relationship: _____ Phone: (____) _____

Fax: (____) _____