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

Applicant Medical History Form

This form is to be completed by your physician and sent by him/her directly back to New Life K9s by mail or fax (805)715-0507.
****Please sign the release below before giving the form to your *physician.*****

Dr. _____ **Patient Release**

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?

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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*

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Client Reference — Service Provider

(This page is to be completed by the applicant.)

Applicant Name: _____ Date: _____

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

I hereby give my permission for the below-stated service provider(s) 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.

_____ _____
Applicant Name (Please print clearly) Applicant Signature

Service Provider Contact Information

Name:_____

Relationship:_____ Phone: (____)_____

Fax: (____)_____

Name:_____

Relationship:_____ Phone: (____)_____

Fax: (____)_____

Name:_____

Relationship:_____ Phone: (____)_____

Fax: (____)_____