LEADER DOGS FOR THE BLIND

1039 S. Rochester Road | Rochester Hills, MI 48307-3115
248.651.9011 ***phone***
clientservices@leaderdog.org ***email***
248.601.3230 ***fax***

PHYSICIAN'S REPORT OF MEDICAL HISTORY

Patient's Name _____ **Date of Birth** _____

Physician's Name _____

Physician's Address _____

Telephone _____ **Fax** _____

Applicant has been a patient since _____

CARDIAC			
	Yes	No	Explain if Yes
Heart Surgery (type/date)			
Hypertension			
Arrhythmia			
Heart Attack			
Coronary Artery Disease			
Mitral Regurgitation			
Syncope/Fainting			
Anemia			
Additional Comments			

NEUROLOGICAL			
	Yes	No	Explain if Yes
Seizures (type/frequency/date of last seizure)			
TBI (date)			
Headache/Migraines (type/frequency)			
Multiple Sclerosis			
Cerebral Palsy			
Stroke (date/residual)			
Neuropathy			
Affects Hands and/or Feet			
Additional Comments			

ORTHOPEDIC			
	Yes	No	Explain if Yes
Back Injuries			
Muscle/Skeletal Disease			
Fractures (location/ date)			
Arthritis (type)			
Chronic Pain			
Foot/Knee Injuries			
Shoulder/arm/ wrist injury			
Amputations			
Prosthetic or orthotic devices			
Reliance on walker/wheelchair /support cane			
Additional Comments			

PULMONARY			
	Yes	No	Explain if Yes
Asthma			
Shortness of Breath			
Lung Disease			
Allergies			
Obstructive Sleep Apnea			
Uses O2/ C-Pap			
COPD			
Emphysema			
Chronic Bronchitis			
Smoker			

Patient's Name: _____

GI/GU			
	Yes	No	Explain if Yes
Ulcers			
Reflux			
Kidney Disease			
Liver/Gall Bladder Disease			
Incontinence			
IBS			
Additional Comments			

INFECTIOUS DISEASES			
	Yes	No	Explain if Yes
AIDS			
HIV			
MRSA			
Hepatitis (B or C)			
Lyme Disease			
Shingles			
Additional Comments			

ENDOCRINE			
	Yes	No	Explain if Yes
Adrenal Insufficiency			
Diabetes Type 1			
Diabetes Type 2			
Hypothyroidism			
Pituitary Disorder			
Addison's Disease			
Additional Comments			

OTHER DISEASES			
	Yes	No	Explain if Yes
Auto Immune (type)			
Cancer (date, type)			
Organ Transplant			
Additional Comments			

Patient's Name _____

PATIENTS WITH DIABETES

IS PATIENT INSULIN DEPENDENT: □ Yes or □ No

IF YES, IS THIS PATIENT ABLE TO:

- **TEST BLOOD SUGAR INDEPENDENTLY □ Yes or □ No**
- **ADJUST INSULIN INDEPENDENTLY (PER YOUR INSTRUCTIONS)**

DOES PATIENT REQUIRE CHANGE IN DOSAGE DURING SUBSTANTIAL PHYSICAL ACTIVITY? □ Yes or □ No

A) HAS THS BEEN DISCUSSED WITH PATIENT? □ Yes or □ No

B) ARE THE DOSAGE CHANGE RESTRICTIONS READILY ACESSIBLE TO PATIENT? □ Yes or □ No

WHAT INSULIN DELIVERING DEVICE IS USED? _____

A1C BLOOD LEVEL (DATE): _____ **(*Required*)**

SCHEDULE OF BLOOD SUGAR TESTING: _____

CAN THE PATIENT RECOGNIZE SIGNS OF AN IMPENDING REACTION? □ Yes or □ No

Please describe signs: _____

_____

_____

IN THE EVENT OF A HYPOGLYCEMIC REACTION, WHAT IS THE PREFERRED GLUCOSE SUPPLEMENT? *(apple juice, glucose tabs, etc.)*: _____

_____

WHAT METHOD DOES PATIENT USE TO MONITOR GLUCOSE LEVEL? _____

FREQUENCY OF HYPOGLYCEMIC OR HYPERGLYCEMIC REACTIONS: _____

HOSPITALIZATIONS OR EMERGENCY VISITS DUE TO UNSTABLE BLOOD SUGAR LEVELS *(please indicate dates)*: _____

_____

DOES THIS PATIENT CONSISTENTLY COMPLY WITH:

- **BLOOD SUGAR TESTING □ Yes or □ No**
- **DIETARY RESTRICTIONS □ Yes or □ No**
- **INSULIN ADMINISTRATION □ Yes or □ No**
- **ROUTINE FOOT CARE □ Yes or □ No**

STATUS of DIABETES

☐ STABLE

☐ BRITTLE

DIABETES HISTORY/NARRATIVE: _____

_____

_____

_____

_____

_____

_____

_____

_____

Patient's Name: _____

PHYSICAL EXAM

HEIGHT _____ **WEIGHT** _____

BLOOD PRESSURE _____ **HEART RATE** _____

LEGALLY BLIND □ **Yes or** □ **No** **CAUSE OF BLINDNESS:** _____

HEARING LOSS □ **Yes or** □ **No** **IF YES, CAUSE OF HEARING LOSS:** _____

HEARING AIDS □ **Yes or** □ **No** / □ **Left or** □ **Right** **COCHLEAR IMPLANT** □ **Yes or** □ **No**

IF APPLICANT HAS HEARING LOSS, PLEASE INCLUDE OR FORWARD RECENT AUDIOMETRIC DATA.
COMMENTS: _____

BALANCE □ **Normal or** □ **Abnormal:**

_____

_____

GAIT □ **Normal or** □ **Abnormal:**

_____

_____

REFLEXES □ **Normal or** □ **Abnormal:**

_____

_____

COORDINATION □ **Normal or** □ **Abnormal:**

_____

_____

FEET □ **Normal or** □ **Abnormal:**

_____

_____

DOES THIS INDIVIDUAL SUFFER FROM ANY CONDITION(S) LIMITING THE FOLLOWING: STANDING, WALKING, CARRYING, LIFTING, STOOPING, SQUATTING, BENDING OR PARTICIPATING IN GROUP INTERACTIONS? PLEASE SPECIFY THE CONDITION AND RECOMMENDED RESTRICTIONS, PRECAUTIONS OR MODIFICATIONS:

_____

_____

PLEASE LIST ANY INJURY OR ILLNESS REQUIRING A HOSPITAL STAY IN THE PAST 5 YEARS.
Indicate dates/diagnosis/treatments

_____

_____

_____

_____

_____

_____

_____

Patient's Name _____

MENTAL HEALTH SECTION

Is the applicant emotionally and mentally stable? □ Yes or □ No

If no, please describe:

FOR ANY LISTED MENTAL HEALTH CONDITIONS	
Date	
Agency/Hospital	
Phone Number	
Frequency of Treatment	
Attending Physician/Therapist	

CONDITIONS			
	Yes	**No**	**Explain if Yes**
Diagnosed Mental Illness			
Psychiatric Hospitalization (date/ diagnosis)			
Depression			
Anxiety			
Dementia/ memory loss			
Eating Disorder			
Sleeping Disorder			
Learning Disorder			
Suicidal Ideations			
Alcohol/Substance Abuse (Substance/ Date of Sobriety)			
Additional Comments			

Patient's Name: _____

PLEASE LIST OR ATTACH CURRENT MEDICATIONS

Name of medication	Condition	Dosage	Route	Frequency

MEDICATION ALLERGY: □ YES or □ NO

_____

_____

_____

FOOD ALLERGIES: _____

_____

_____

RECOMMENDED DIET: _____

_____

_____

Patient's Name: _____

Your patient has applied to Leader Dogs for the Blind for one of the following programs. All Leader Dog programs require sustained physical activity, as well as cognitive, emotional and social functioning.

Leader Dog's three-week Guide Dog Program can be stressful at times. Clients participate in training activities from 6 am to 9 pm, 6 days a week with rest periods and meal breaks. Clients are expected to be independent with their health care needs. Clients in training walk 30–45-minute routes with their dog twice a day, in all weather conditions. While walking, clients may experience sudden, brief increases in speed or pull, or be twisted by unexpected tugs to the left or right. Guide dogs typically range in size from 50 to 75 pounds, walk at a minimum speed of 1 to 1 ½ miles per hour, and exert a down and forward pull of at least 2 to 3 pounds. Guide dogs have a working life span of 8-10 years during which the client will be expected to continue regular physical care and training to maintain the team's skills.

Leader Dog's one-week Orientation & Mobility Program Clients participate in training activities from 7:30am to 3:30pm during 5 days with rest periods and meal breaks. Clients are expected to be independent with their health care needs. Clients in training walk 30-45-minute routes 4 to 6 times per day, in all weather conditions.

Leader Dog's Home Delivery Program for Guide Dog or Orientation & Mobility is scheduled based on the client's needs and abilities for up to 7 hours and over the course of 5-14 days with rest periods and meal breaks. Clients are expected to be semi-independent with their healthcare needs. Clients are expected to walk up to 30–45-minute routes multiple times per day in all weather conditions.

Leader Dog's one-week Teen Summer Camp (for 16 & 17 year olds) activities run from 8 am to 10 pm, 5 days a week with rest periods and meal breaks. Clients are expected to walk 30-45 minute routes 4 to 6 times per day in all weather conditions.

Based on my knowledge of this patient and the information provided to me, it is my opinion that this patient:

- ☐ **can** ☐ **cannot** **safely participate in the described guide dog program.**
- ☐ **can** ☐ **cannot** **safely participate in the described orientation and mobility program.**
- ☐ **can** ☐ **cannot** **safely participate in the described home delivery program.**
- ☐ **can** ☐ **cannot** **safely participate in the described teen summer camp.**

Do you have any concerns about your patient completing any of these programs: □ Yes or □ No
If yes, please explain:

_____

_____

_____

_____

_____

_____

Patient's Name: _____

Physician's Signature (required) _____

Physician's Name (printed) _____

Date of Last Exam_____Date of Report _____

Once completed, please return to Leader Dogs for the Blind!

By email: clientservices@leaderdog.org
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