OccuPaws Guide Dog Association

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PHYSICIAN'S REPORT

Applicant: This form must be completed by your primary physician upon an examination.

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 rigorous training, both physical and mental. They will spend 10 to 15 days training and will be expected to walk a minimum of an hour twice daily in all types of terrain, with their guide dog, regardless of weather conditions. Your information will help us provide your patient with the training and instruction most suited to their needs. The Ophthalmologist's report and verification of blindness is a separate form. 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: _____

Is applicant legally blind? ☐ Yes ☐ No **Cause of blindness**: _____

Does the applicant have any of the following medical problems? (please answer yes or no)

Arthritis _____	Allergies _____	Asthma _____	Cancer _____
Circulatory Problems _____	Back Problems _____	Amputations _____	Addictions _____
High Blood Pressure _____	Seizures _____	Heart Disorder _____	Knee/Hip _____
Psychiatric Problems _____	Epilepsy _____	Intestinal Problems _____	Ulcers _____
Headaches _____	Foot Trouble _____	Infectious Diseases _____	Fainting _____
Neuropathy _____	Dexterity Problems _____	Nervousness _____	Speech Impairments ____

If yes, please explain _____

_____

Please list any surgeries _____

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

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

Does applicant have a learning disorder? _____

Does applicant have any impairments of the use of either leg/foot? _____ **Hand/arm** _____

Does applicant have any limitations? Please explain _____

Is applicant diabetic? _____ **If yes please complete diabetic report.**

***Date of exam on which report is based:** _____

_____

_____
Physician's Signature

Doctor's name: _____
Please print

Telephone: (____) _____

Hospital / Clinic Stamp