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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.**

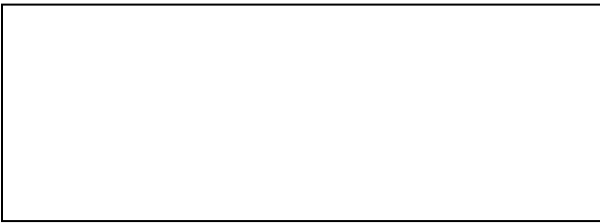
***Is applicant stable enough to undergo the rigors of training away from home for 28 days?** _____

Date of exam on which report is based: _____

Physician's Signature

Doctor's name: _____
Please print

Telephone: (____) _____



Hospital / Clinic Stamp