Applicant Medical History Form

This form is to be completed by your physician and sent directly to Mountain High Service Dogs Inc. via email to team@mtnhighservicedogs.com or fax to 719-487-1489.

Information Release:

Dr. ___________________________,

Please release the requested medical information regarding my condition to the above identified organization. This information will be used to help determine my abilities in regards to the placement of an assistance dog.

Applicant's Name (please print):____

Applicant's Signature:_______________________________

Date:____________________

Doctor's Name:____

Type of practice: ____

Address:____

City:____________________ County:_________________ State:________ Zip:________

Phone: ______________________________

Fax:_________________________________

Patient Information:

What is this patient's primary diagnosis?_______________________________________

What is the cause of this diagnosis?____

Are there significant secondary diagnosis?__________________________( ) Yes ( ) No

If yes, please describe: ____

At what age was he/she diagnosed?_______________ Is this diagnosis progressive? ( ) Yes ( ) No

Is there an incapacity due to alcohol or drug abuse?_____( ) Yes ( ) No

Does the patient smoke?_____( )Yes ( )No

PLEASE CIRCLE ALL THAT APPLY:

This effects of this patient's diagnosis include:

Deafness Speech impairment Reduced stamina Hearing loss

Coordination problems Limited mobility Memory loss Spasticity

Delayed development Vision impairment Muscular weakness

*Other:*_____

Does this patient have trouble with...

Allergies Chronic pain Heightened emotions Depression

Seizures Balance Brittle bones Heat/Cold Sensitivity

Does this patient use any of the following aids or assistive devices?

Prosthesis Leg brace Wheelchair- manual Wheelchair- electric

Wrist brace Hearing aid Crutch/cane Walker

*Other:*_____

Does this patient...

Drive Travel by bus Travel by airplane Other public transportation

Current number of hours of attendant care per week:_____

ADL= Activities of Daily Living

Is this patient:	Please Circle Below
A. Able to exercise judgment and make decisions necessary for ADL?	Yes Minimally No
B. Able to sustain an attention span?	Yes Minimally No
C. Manifesting inappropriate behavior beyond his or her control?	Yes Minimally No
D. Able to control physical and motor movement sufficient to sustain ADL?	Yes Minimally No
E. Capable of perception and memory to the degree necessary to sustain ADL?	Yes Minimally No
F. Able to follow directions and learn to the degree necessary to sustain ADL?	Yes Minimally No
G. Under medication which impairs physical or mental functioning?	Yes Minimally No
H. Capable of decisions concerning self and others needs and safety?	Yes Minimally No

Can you recommend this individual for an assistance dog?_____( ) Yes ( ) No

Comments: _____

_____

_____

Do you feel MHSD needs to speak with you about this applicant? ( ) Yes ( ) No

Physician Signature:_____ Date:_____