GUIDE DOGS OF AMERICA

General Physician's Report

This General Physician's Report is being requested in connection with an application for a guide dog. We require a recent physical exam and complete medical history for each of our prospective students. Please complete all sections of this form and if a section is not applicable, please note "n/a" in that section. If you have any questions, please call the Admissions department at the below number. Thank you in advance for your cooperation which is greatly appreciated.

SEND TO:
Guide Dogs of America
13445 Glenoaks Blvd.
Sylmar, CA 91342
Attn: Admissions

Telephone & Fax: 818-833-6428
Email: Admissions@GuideDogsofAmerica.org

PATIENT INFORMATION					
Last Name		**First**		**M.I.**	
Date of Birth					
In your opinion, will the patient be able to undergo the necessary 2-3 weeks of training to learn to work with a Guide Dog?			**YES** ☐		**NO** ☐
Please elaborate on any results that you feel may help or hinder the patient's ability to finish the training:					

TB/PPD TEST

This test is mandatory and must be current within 1 year of patient's admission to our program

Date of Test:		**Positive:** ☐	**Negative:** ☐
If the TB/PPD test is positive, a chest x-ray is required			
Date of x-ray:		**Normal:** ☐	**Abnormal:** ☐

How long have you or your practice attended to this patient?				
Has the patient had any significant illness, injury or surgery in the last 2 years?			**YES** ☐	**NO** ☐
If yes to the above, please explain:				
Is the patient able to tolerate long walks of 1 to 2 miles a day?	**YES** ☐	**NO** ☐	**LIMITED** ☐	**UNKNOWN** ☐
Does the patient now use orthotic or prosthetic devices to walk?			**YES** ☐	**NO** ☐
Does the patient demonstrate sufficient motion in upper extremities and have sufficient hand strength for controlling a dog with the left hand?			**YES** ☐	**NO** ☐
Are there motion limitations in the:	**BACK** ☐	**LEGS** ☐	**NECK** ☐	
If yes to any of the above, please explain:				

Gait:	**NORMAL** ☐	**ABNORMAL** ☐
Coordination:	**NORMAL** ☐	**ABNORMAL** ☐
Reflexes:	**NORMAL** ☐	**ABNORMAL** ☐
Sensory:	**NORMAL** ☐	**ABNORMAL** ☐

MEDICATIONS			
Medication:		**Dosage:**	
Medication:		**Dosage:**	
Medication:		**Dosage:**	
Medication:		**Dosage:**	
Medication:		**Dosage:**	
Medication:		**Dosage:**	
Medication:		**Dosage:**	
Medication:		**Dosage:**	
Medication:		**Dosage:**	
Medication:		**Dosage:**	

ALLERGIES
Please list any medications to which the patient may be allergic:
Please list any food allergies:
Please list any other allergies:

DIABETES				
Is the patient diabetic?			**YES** ☐	**NO** ☐
If yes, what type of diabetes:	**TYPE I** ☐		**TYPE II** ☐	
Last HbA1C Value:		**Date:**		
Do you consider patient to be:	**STABLE** ☐		**BRITTLE** ☐	
Are insulin reactions frequent:			**YES** ☐	**NO** ☐
Are insulin reactions severe:			**YES** ☐	**NO** ☐
Name, type and dosage of insulin therapy:				
Is the patient on an insulin pump:			**YES** ☐	**NO** ☐
Type of pump:				
Is patient able to recognize symptoms of hypoglycemia:			**YES** ☐	**NO** ☐
Date of last hospitalization due to hypoglycemia:				
Does the patient have neuropathy:	**HANDS** ☐	**FEET** ☐	**OTHER** ☐ _____	
Does the patient have any other endocrine disorders:			**YES** ☐	**NO** ☐
If yes, please explain:				

SEIZURES **Applicants must be seizure-free for at least 1 year prior to applying to GDA.**			
Has patient had seizures?		**YES** ☐	**NO** ☐
Type of seizures:		**Frequency of seizures:**	
Date of last seizure:		**Duration of seizure:**	
Severity of seizure:			

Does patient have a warning/aura:	**YES** ☐	**NO** ☐
Date of last hospitalization due to seizure:		
Last date anti-seizure medication was checked:		
Results of the last anti-seizure medication level: ***(if Abnormal, please attach results)***	**NORMAL** ☐	**ABNORMAL** ☐

GENERAL HEALTH

Has the patient received an organ transplant:		**YES** ☐	**NO** ☐
Type of transplant:		**Date Received:**	
Hearing:		**NORMAL** ☐	**ABNORMAL** ☐
If hearing is abnormal, a hearing test is required. Please attach results.		**Date of Test:**	

Height:		**Weight:**		**Blood Pressure:**		**Heart Rate:**	

Skin:	**NORMAL** ☐	**ABNORMAL** ☐	**Please explain if abnormal:**
Head:	**NORMAL** ☐	**ABNORMAL** ☐	**Please explain if abnormal:**
Eyes:	**NORMAL** ☐	**ABNORMAL** ☐	**Please explain if abnormal:**
Ears:	**NORMAL** ☐	**ABNORMAL** ☐	**Please explain if abnormal:**
Nose:	**NORMAL** ☐	**ABNORMAL** ☐	**Please explain if abnormal:**
Throat:	**NORMAL** ☐	**ABNORMAL** ☐	**Please explain if abnormal:**
Neck:	**NORMAL** ☐	**ABNORMAL** ☐	**Please explain if abnormal:**
Chest:	**NORMAL** ☐	**ABNORMAL** ☐	**Please explain if abnormal:**
Lungs:	**NORMAL** ☐	**ABNORMAL** ☐	**Please explain if abnormal:**
Breasts:	**NORMAL** ☐	**ABNORMAL** ☐	**Please explain if abnormal:**
Heart:	**NORMAL** ☐	**ABNORMAL** ☐	**Please explain if abnormal:**

Abdomen:	**NORMAL** ☐	**ABNORMAL** ☐	**Please explain if abnormal:**
Hernia:	**NORMAL** ☐	**ABNORMAL** ☐	**Please explain if abnormal:**

Does patient have any of the following conditions:

Amputations	**Foot trouble**
Anemia	**Fractures**
Asthma	**Headaches**
Blood in urine	**Hepatitis**
Chest pains	**Hypertension**
Convulsions/seizures	**Kidney trouble**
Depression/anxiety	**Knee injury**
Eating disorder	**Nervous trouble**
Fatigue	**Stomach ulcers**

If yes to any of the above conditions, please explain:

Is patient following a special medical diet:	**YES** ☐	**NO** ☐

If yes, please explain:

Does patient have an alcohol or substance abuse issue:	**YES** ☐	**NO** ☐
If yes, is the patient in recovery:	**YES** ☐	**NO** ☐
How long has the patient been in recovery:		

Does the patient have HIV:	**YES** ☐	**NO** ☐
Does the patient have AIDS	**YES** ☐	**NO** ☐
Does the patient have hepatitis:	**YES** ☐	**NO** ☐
Does the patient have any other blood-related disease:	**YES** ☐	**NO** ☐

PHYSICIAN'S SIGNATURE

Print Name:			
Physician's Signature:			
Physician's Specialty:			
Physician's Address:			
Physician's Phone:		**Physician's Fax:**	
License #:		**Date:**	