Formatted: Indent: Left: 5"

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		**Phone**			

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:		

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

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:** ☐

MOBILITY				
Is the patient able to tolerate long walks of 1 to 2 miles a day?	**YES** ☐	**NO** ☐	**LIMITED** ☐	**UNKNOWN** ☐
Does the patient 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** ☐
Balance:	**NORMAL** ☐	**ABNORMAL** ☐

MEDICATIONS

Please complete table below or attach a list of current medications	NO CURRENT 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:**	

Does patient have any of the following conditions:

CARDIAC:			**PULMONARY:**		
Arrhythmia	**YES** ☐	**NO** ☐	**Asthma**	**YES** ☐	**NO** ☐
Blood Disorder	**YES** ☐	**NO** ☐	**COPD**	**YES** ☐	**NO** ☐
CAD	**YES** ☐	**NO** ☐	**Emphysema**	**YES** ☐	**NO** ☐
CHF	**YES** ☐	**NO** ☐	**Shortness of Breath**	**YES** ☐	**NO** ☐
Fainting	**YES** ☐	**NO** ☐			
Hypertension	**YES** ☐	**NO** ☐			
MI	**YES** ☐	**NO** ☐			

If yes to any of the above, please explain:

NEUROLOGICAL:			**GASTROINTESTINAL:**		
CP	**YES** ☐	**NO** ☐	**Crohn's Disease**	**YES** ☐	**NO** ☐
CVA	**YES** ☐	**NO** ☐	**GIRD**	**YES** ☐	**NO** ☐
Headaches/Migraines	**YES** ☐	**NO** ☐	**IBS**	**YES** ☐	**NO** ☐
MS	**YES** ☐	**NO** ☐	**Ulcers**	**YES** ☐	**NO** ☐
TBI	**YES** ☐	**NO** ☐			

If yes to any of the above, please explain:					
ORTHOPEDIC:			**BEHAVIORAL HEALTH:**		
Amputation/Prosthesis	YES ☐	NO ☐	ADD/ADHD	YES ☐	NO ☐
Arthritis	YES ☐	NO ☐	Anxiety	YES ☐	NO ☐
Neck/Back Injury	YES ☐	NO ☐	Bipolar Disorder	YES ☐	NO ☐
Shoulder/Arm Injury	YES ☐	NO ☐	Depression	YES ☐	NO ☐
Leg/Ankle Injury	YES ☐	NO ☐	Eating Disorder	YES ☐	NO ☐
Foot Injury	YES ☐	NO ☐	Learning Disorder	YES ☐	NO ☐
Hernia	YES ☐	NO ☐	Sleep Disorder	YES ☐	NO ☐
Muscle Fatigue/Weakness	YES ☐	NO ☐	Alcohol/Substance Abuse	YES ☐	NO ☐
If yes to any of the above, please explain:					

Is patient following a special medical diet:	YES ☐	NO ☐
If yes, please explain:		

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** ☐
This training is a strenuous, 3-week residential program in a dormitory setting. Students will train with a guide dog for 12-14 hours a day, 6 days a week in all weather conditions. Students must be able to tolerate walks of 1-2 miles, twice a day. While walking with their dog, there is a steady down and forward pull on the left arm and strain on the back and leg muscles; and students may experience sudden increases in speed or pull, or be pulled unexpectedly to the left or right. Students must demonstrate sufficient motion in upper extremities and have sufficient hand strength for controlling a dog on leash. Students must be able to independently manage any chronic health conditions and function in an emotionally stressful environment. **In your opinion, will the patient be able to undergo this training?**	**YES** ☐	**NO** ☐
If no, please elaborate:		

PHYSICIAN'S SIGNATURE

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