Guiding Eyes for the Blind
611 Granite Springs Road, Yorktown Heights, New York 10598
PHONE 914 243-2216 admissions@guidingeyes.org FAX 914 243-2232

PHYSICIAN'S REPORT

Patient's Name: ______________________________ **Date of Birth:** ____________

Physician's Name: ______________________________

Physician's Address: ______________________________

Telephone: ______________________**Fax:**______________________

Acquiring complete medical information is essential in determining if the applicant can complete our program successfully. In addition, the information we are requesting is vital in assessing special needs that could require modification to our program. Please check yes or no for each item in every category and provide explanations when applicable.

MEDICAL HISTORY

Please answer yes or no and explain when indicated, including details requested as indicated in parentheses.

CARDIAC					NEUROLOGICAL			
	Yes	No	Explain if Yes			Yes	No	Explain if Yes
Heart Surgery (type/date)					Seizures (type/frequency/date of last seizure)			
Hypertension					TBI (date)			
Arrhythmia					Headache/ Migraines (type/frequency)			
MI (date)					M.S.			
CAD					C.P. (disability)			
SOB					M.R.			
Syncope					Stroke (date/residual)			
Anemia					Other			
Other								
Additional Comments					Additional Comments			

ORTHOPEDIC					PULMONARY			
	Yes	No	Explain if Yes			Yes	No	Explain if Yes
Back Injuries					Asthma			
Muscle/Skeletal Disease					SOB			
Fractures (location/ date)					Lung Disease			
Arthritis (type)					Allergies			
Chronic Pain					C.P. (disability)			
Foot/Knee Injuries					Uses O2/ C-Pap			
Shoulder/arm/ wrist injury					Other			
Other								
Additional Comments					Additional Comments			

Patient's name: ____________________

GI/GU					INFECTIOUS DISEASES			
	Yes	No	Explain if Yes			Yes	No	Explain if Yes
Ulcers					AIDS			
Reflux					HIV			
Kidney Disease					MRSA			
Liver Gall Bladder Disease					Hepatitis (B or C)			
Rectal Problems					Other			
Incontinence								
IBS								
Other								
Additional Comments					Additional Comments			

ENDOCRINE					MENTAL HEALTH			
	Yes	No	Explain if Yes			Yes	No	Explain if Yes
Adrenal Insufficiency					Diagnosed Mental Illness			
Hypothyroidism					Psychiatric Hospitalization (date/ diagnosis)			
Diabetes (complete attached sheet)					Depression			
Other					Anxiety			
					Dementia/ memory loss			
					Eating Disorder			
					Sleeping Disorder			
					Alcohol - Substance Abuse (Substance/Date of Sobriety)			
					Other			
Additional Comments					Additional Comments			

OTHER DISEASES					FOR ANY MENTAL HEALTH TREATMENTS LISTED ABOVE	
	Yes	No	Explain if Yes		Date	
Auto Immune (type)					Attending Physician/Therapist	
Cancer (date, type)					Frequency of Treatment	
Other					Agency/Hospital	
Additional Comments					Address	

Patient's Name: ______________________________

PHYSICAL EXAM

HEIGHT: ____________________ **WEIGHT:** ____________________

BLOOD PRESSURE: ____________________ **HEART RATE:** ____________________

HEARING (Normal or Abnormal): ____________ **HEARING AIDS (Yes or No) (left / right):** ________

GAIT (Normal or Abnormal): ____________ **REFLEXES (Normal or Abnormal):** ____________

COORDINATION (Normal or Abnormal): ________ **FEET (Normal or Abnormal):** ____________

***** PPD TESTING IS REQUIRED FOR ALL STUDENTS WHO PLAN TO TRAIN ON CAMPUS (see attached sheet) *****

DATE GIVEN: ____________ **RESULT:** ____________________

POSITIVE RESULT- INCLUDE CHEST X-RAY DATE: ____________ **READING:** ____________

DATE OF LAST TETANUS: ____________ **DATE OF BOOSTER IF NEEDED:** ____________

****** EKG TESTING IS REQUIRED FOR ALL STUDENTS 65 YEARS OLD AND OLDER OR IF CARDIAC DISEASE IS NOTED. ******

EKG DATE (Please include report): ____________ **READING:** ____________________

PLEASE LIST ANY INJURY OR ILLNESS REQUIRING A HOSPITAL STAY IN THE PAST 5 YEARS.
Indicate dates/diagnosis/treatments: ______________________________

____

____

____

____

MEDICATION ALLERGY: ______________________________

PLEASE LIST CURRENT MEDICATIONS:

Name of medication	Dosage	Frequency	Route

FOOD ALLERGY: ______________________________

RECOMMENDED DIET: ______________________________

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Mantoux Tuberculin, PPD Skin Test Record Form

Patient Information

Name: ____________________
Address: ____________________
City/Town: ____________________
Telephone: ____________________
Home Work

Skin Test Information

Administrator Name: ____________________
Date/Time Administered: ____________________
Arm on which Administered: ____________________
Manufacturer of PPD Solution: ____________________
Expiration Date of PPD Solution: ____________________
Lot #: ____________________

Results

Iduration ____________mm Date/Time of Reading ____________________
Comments and Adverse Reactions, if any: ____________________
____

Name of Reader: ____________________

Signature: ____________________

Patient's Name: ____

FOR DIABETIC PATIENTS

A1C BLOOD LEVEL (DATE) : ______________________________________(Required)

DIET: ____

ORAL MEDICATIONS:

____

____

____

INSULIN TYPE AND SCHEDULE:

AM: ______________________________________
NOON: ______________________________________
PM: ______________________________________
HS: ______________________________________

SLIDING SCALE COVERAGE: ______________________________________

INSULIN PUMP: ______________________________________

INSULIN PUMP BASAL RATE: ______________________________________

UNITS PER CARBOHYDRATE: ______________________________________

DOES PATIENT TEST HIS/HER BLOOD SUGAR INDEPENDENTLY? ______________________

METHOD USED: ______________________________________

____

SCHEDULE OF TESTING: ______________________________________

DOES THIS PATIENT INDEPENDENTLY ADJUST INSULIN COVERAGE AS PER YOUR INSTRUCTION? ________

____

FREQUENCY OF HYPOGLYCEMIC OR HYPERGLYCEMIC REACTIONS: ______________________

____

HOSPITALIZATIONS OR EMERGENCY VISITS DUE TO UNSTABLE BLOOD SUGAR LEVELS. PLEASE INDICATE DATES:

____

____

PLEASE INDICATE SECONDARY COMPLICATIONS AND DEGREE OF SEVERITY:

____

____

Patient's Name: ____

Your patient has applied to our school for a guide dog. Guiding Eyes for the Blind's three week residential training program can be stressful at times. The program requires sustained physical, cognitive, emotional, and social functioning from 6am to 9pm, 6 days a week with rest periods and meal breaks. Students are expected to be independent with their health care needs and able to adapt to dormitory life. Students in training walk 30 to 45 minutes routes with their dog twice a day, in all but extreme weather conditions. Guide Dogs typically range in size from 50 to 75 pounds, walk at a minimum speed of 1 to 1 ½ miles per hour and exert a down and forward pull of at least 2 to 3 pounds. While walking, students may experience sudden, brief increases in speed or pull, or be twisted by unexpected tugs to the left or right.

Does this individual suffer from any condition(s) limiting the following: standing, walking, carrying, lifting, stooping, squatting, bending or participating in group interactions? Please specify the condition and recommended restrictions, precautions or modifications:

____

____

____

Based on my knowledge of this patient and the information provided to me, it is my opinion that this patient _____should ______should not be able to participate in the described course of instruction.

Physician's Signature ____ **Date of Exam** ________________
(required)

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