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:** ________________________

MEDICAL HISTORY

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				Neuropathy			
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				Obstructive Sleep Apnea			
Foot/Knee Injuries				Uses O2/ C-Pap			
Shoulder/arm/ wrist injury				COPD			
Amputations				Emphysema			
Prosthetic or orthotic devices				Chronic Bronchitis			
Additional Comments				Additional Comments			

Patient's Name: ______________________________

GI/GU	Yes	No	Explain if Yes
Ulcers			
Reflux			
Kidney Disease			
Liver Gall Bladder Disease			
Rectal Problems			
Incontinence			
IBS			
Additional Comments			

INFECTIOUS DISEASES	Yes	No	Explain if Yes
AIDS			
HIV			
MRSA			
Hepatitis (B or C)			
Lyme Disease			
West Nile Virus			
Herpes Zoster			
Additional Comments			

ENDOCRINE	Yes	No	Explain if Yes
Adrenal Insufficiency			
Diabetes Type 1			
Diabetes Type 2			
Hypothyroidism			
Pituitary Disorder			
Addison's Disease			
Additional Comments			

MENTAL HEALTH	Yes	No	Explain if Yes
Diagnosed Mental Illness			
Psychiatric Hospitalization (date/ diagnosis)			
Depression			
Anxiety			
Dementia/ memory loss			
Eating Disorder			
Sleeping Disorder			
Alcohol/Substance Abuse (Substance/ Date of Sobriety)			
Additional Comments			

OTHER DISEASES	Yes	No	Explain if Yes
Auto Immune (type)			
Cancer (date, type)			
Organ Transplant			
Additional Comments			

FOR ANY MENTAL HEALTH TREATMENTS LISTED ABOVE	
Date	
Attending Physician/Therapist	
Frequency of Treatment	
Agency/Hospital	
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

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 OR ATTACH CURRENT MEDICATIONS:

Name of medication	Dosage	Route	Frequency

FOOD ALLERGY: ______________________________

RECOMMENDED DIET: ______________________________

Patient's Name: ____

FOR DIABETIC PATIENTS

DOES THIS PATIENT CONSISTENTLY COMPLY WITH:

☐ BLOOD SUGAR TESTING ☐ INSULIN ADMINISTRATION
☐ DIETARY RESTRICTIONS ☐ ROUTINE FOOT CARE

DIABETIC STATUS

☐ STABLE

☐ BRITTLE

IS THIS PATIENT ABLE TO:

☐ TEST BLOOD SUGAR INDEPENDENTLY
☐ ADJUST INSULIN INDEPENDENTLY (PER YOUR INSTRUCTIONS)

A1C BLOOD LEVEL (DATE): ______________________________________ **(Required)**

SCHEDULE OF BLOOD SUGAR TESTING: ______________________________________

DIABETES MEDICATIONS:

Name of medication	Dosage	Route	Frequency

INSULIN TYPE AND SCHEDULE:

	Name of Medication	Dosage	Route
AM			
NOON			
PM			
HS			

SLIDING SCALE COVERAGE

INSULIN PUMP TYPE AND BASAL RATE: ______________________________________

UNITS PER CARBOHYDRATE: ______________________________________

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 minute 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 ☐ can ☐ cannot safely participate in the described course of instruction.

Physician's Signature ______________________________________ **Date of Exam** ______________
(required)

Running Guide Consent

Guiding Eyes for the Blind, offers a Running Guide program for qualified applicants who are active runners. Students participating in this program will run or jog a minimum of 2 miles, twice a week. Students will be supervised by a Guiding Eyes for the Blind staff member. Please indicate if your patient is medically stable and fit to participate in this program.

It is my medical opinion that this patient ☐ can participate safely ☐ cannot participate safely.

Physician's Signature____________________________**Date**________________________________

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