

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				Smoker			

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				Lyme Disease			
Incontinence				West Nile Virus			
IBS				Herpes Zoster			
Additional Comments				Additional Comments			

ENDOCRINE				MENTAL HEALTH			
	Yes	No	Explain if Yes		Yes	No	Explain if Yes
Adrenal Insufficiency				Diagnosed Mental Illness			
Diabetes Type 1				Psychiatric Hospitalization (date/diagnosis)			
Diabetes Type 2				Depression			
Hypothyroidism				Anxiety			
Pituitary Disorder				Dementia/ memory loss			
Addison's Disease				Eating Disorder			
Additional Comments				Sleeping Disorder			
				Alcohol/Substance Abuse (Substance/Date of Sobriety)			
				Additional Comments			

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

Patient's Name _____

PHYSICAL EXAM

HEIGHT _____ WEIGHT _____

BLOOD PRESSURE _____ HEART RATE _____

HEARING Normal or Abnormal: _____ HEARING AIDS Yes or No / Left or 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 _____

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

EKG DATE (Please include report) _____ READING _____

DATE OF LAST TETANUS _____ DATE OF BOOSTER IF NEEDED _____

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: _____

Medical History/Narrative: _____

Patient's Name: _____

FOR DIABETIC PATIENTS

DOES THIS PATIENT CONSISTENTLY COMPLY WITH:

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

IS THIS PATIENT ABLE TO:

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

DIABETIC STATUS <input type="checkbox"/> STABLE <input type="checkbox"/> BRITTLE

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:

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

COVID-19

1. Has this patient reported exposure to the COVID-19 virus? YES NO
2. Has this patient presented or reported symptoms of COVID-19? YES NO
3. Has this patient been tested for the COVID-19 virus? (results) YES NO
Result _____ Date _____
4. Have you discussed your patient's COVID-19 risk factors with them, including how risks pertain to training with a guide dog at this time? YES NO
5. Has the patient been vaccinated against COVID-19? YES NO
Vaccine type _____ Date of 1st shot _____ Date of 2nd shot _____

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 (required) _____

Date of Exam _____ Date of Report _____