



### PHYSICIAN'S REPORT

Client Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Physician's Name: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

Your client has applied to our school for a guide dog. Acquiring complete medical information is essential in determining if the applicant can complete our program successfully. Please check yes or no for each item in every category and provide explanations when applicable.

#### Diagnoses/Significant Health Conditions (Include a Medical History Summary if available)

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

#### Current Medications (Complete or attach a printed list)

Medication:	Dose:	Frequency:	Diagnosis:

Does the client take medications independently?  Yes  No

\*\*\*Medication Allergies/Sensitivites: \_\_\_\_\_ \*\*\*

#### **TUBERCULOSIS SCREENING IS REQUIRED FOR ALL PLANNING TO TRAIN ON CAMPUS**

Please complete standard TB risk assessment. If TB testing is indicated, testing is required for on campus training within two years of client's training start date.

TB testing indicated  No risk factors/test not indicated

PPD/TB test Results:  Negative  Positive Date: \_\_\_\_\_

If positive, chest x-ray is required: Date of x-ray: \_\_\_\_\_ Result: \_\_\_\_\_

#### **EKG TESTING REQUIRED FOR ALL CLIENTS WITH DOCUMENTED CARDIAC DIAGNOSIS**

EKG Date (include report): \_\_\_\_\_ Reading: \_\_\_\_\_

Client Name: \_\_\_\_\_

### General Physical Exam

Blood pressure: \_\_\_\_\_ Pulse: \_\_\_\_\_ Height: \_\_\_\_\_ Weight: \_\_\_\_\_

System	Normal Findings?	Comments/Description
Behavioral/Mental Health	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Cardiovascular	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Cognitive	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Ears/Nose/Throat	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Endocrine	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Extremities	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Gastrointestinal	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Head/Face/Neck	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Integumentary	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Genitourinary	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Musculoskeletal	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Neurological	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Pulmonary	<input type="checkbox"/> Yes <input type="checkbox"/> No	

Please check any of the following conditions the client has and explain in space provided below.

<input type="checkbox"/> Seizures – **indicate type/frequency/date of last **	<input type="checkbox"/> Wear hearing aid/implants (please circle) Right/Left	<input type="checkbox"/> Substance abuse - **If in recovery, how long? **
<input type="checkbox"/> Sensory/Neurological Deficit	<input type="checkbox"/> Hearing loss	<input type="checkbox"/> Asthma
<input type="checkbox"/> Cognitive Impairment	<input type="checkbox"/> Altered gait	<input type="checkbox"/> Shortness of breath
<input type="checkbox"/> Memory Loss	<input type="checkbox"/> Syncope	<input type="checkbox"/> Cancer
<input type="checkbox"/> Traumatic brain injury	<input type="checkbox"/> Dizziness	<input type="checkbox"/> Infectious disease
<input type="checkbox"/> PTSD	<input type="checkbox"/> Excessive Fatigue	<input type="checkbox"/> Autoimmune disease
<input type="checkbox"/> Cerebral palsy	<input type="checkbox"/> Orthopedic injuries	<input type="checkbox"/> Adrenal insufficiency
<input type="checkbox"/> Neuropathy	<input type="checkbox"/> Chronic pain	<input type="checkbox"/> Diabetes
<input type="checkbox"/> Impaired mobility	<input type="checkbox"/> Uses adaptive equipment	<input type="checkbox"/> Organ transplant

**Explain any conditions checked above:** \_\_\_\_\_

**Food Allergies:** \_\_\_\_\_ **Recommended Diet:** \_\_\_\_\_

**Does this client have an allergy to dogs?**  Yes  No

**If yes, what type of reaction do they experience?** \_\_\_\_\_

**Is this client treated by a Psychiatrist / Therapist?**  Yes  No

**Hospitalizations/Procedures (within last year)**

Date:	Reason:	Date:	Reason:

**FOR CLIENTS WITH DIABETES**

Type 1  Type 2                      Status of Diabetes:  Stable  Unstable

**Indicate the client's prescribed management measures:**

- Blood Sugar Testing  Insulin Administration  Insulin Pump
- Dietary Restrictions  Routine Foot Care  Sliding Scale

**Is client able to:**

- Test blood sugar independently  
Indicate Frequency: \_\_\_\_\_
- Adjust insulin independently (per MD instructions)

Does the client consistently comply with all prescribed diabetes management measures?  Yes  No

A1C (date): \_\_\_\_\_ Frequency/Type Severe Hypo/Hyperglycemic Episodes: \_\_\_\_\_

Can the client recognize signs of an impending reaction?  Yes  No

Please describe signs: \_\_\_\_\_

Preferred glucose replacement in the event of Hypoglycemia? (apple juice, glucose) \_\_\_\_\_

Hospitalizations/Emergency Visits due to unstable blood sugar (dates): \_\_\_\_\_

Will client's diabetes affect their ability to walk and care for a guide dog regularly?  Yes  No

If Yes, please explain: \_\_\_\_\_

**Physical Fitness/Stamina**

Guiding Eyes for the Blind's two-week residential training program can be stressful at times. The program requires sustained physical, cognitive, emotional, and social functioning from 7am to 9pm, 6 days a week with rest periods and meal breaks. Clients are expected to be independent with their health care needs and able to adapt to dormitory style life. Clients in training walk ½ to ¾ mile 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, clients may experience sudden, brief increases in speed or pull, or be twisted by unexpected tugs to the left or right.

Please rate client's physical fitness and stamina on the following criteria:

- Excellent** - Client is able to participate in vigorous physical activity such as running, playing vigorous sports and/or heavy aerobic or muscle building exercise.
- Moderate** - Client is able to participate in moderate physical activity such as jogging, moderate aerobic or muscle building exercise for over 30 minutes with no breaks.
- Mild** - Client is able to participate in mild physical activity such as walking, light aerobic or muscle building exercise for 30 minutes with no breaks.
- Poor** - Client has difficulty with physical activity such as walking long distances and light exercise. Would need to take multiple breaks over 30 minutes of exercise.
- Very Poor** - Client has difficulty with daily tasks - walking short distances, stairs or lifting/carrying items (5-15 lbs).

Client Name: \_\_\_\_\_

**Does this client 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:**

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In your opinion will the client be able to walk at a moderate pace , for approximately one-half hour to one hour twice daily, in all but extreme weather?

Yes  No

If no, please explain: \_\_\_\_\_

A guide dog can enhance a person's life in many ways, but also requires a great deal of care. A guide dog requires daily feeding, watering, grooming, and exercise (in form of guide work). In your opinion, will the client be able to care for an active dog?

Yes  No

If no, please explain: \_\_\_\_\_

Our training program requires each client to stay on our campus and or work daily with their guide dog and our training staff. This program involves daily walking and working with their dog, classroom type lectures and providing their dog with numerous relief times. In your opinion, is this client physically, mentally and emotionally able to participate in our two-week program?

Yes  No

If no, please explain: \_\_\_\_\_

### Running Guide Consent

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

**It is my medical opinion that this client**  can participate safely  cannot participate safely

**Based on my knowledge of this client and the information provided to me, it is my opinion that this client**  can  cannot safely participate in the described course of instruction.

**Physician's Signature (required):** \_\_\_\_\_

**Date of Exam:** \_\_\_\_\_

**Date of Report:** \_\_\_\_\_