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

PHYSICIAN'S REPORT

Patient's Name _____ **Date of Birth** _____

Physician's Name _____

Telephone _____ **Fax** _____

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.

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			
	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	
Agency/Hospital	
Phone Number	
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:** _____

Medical History/Narrative: _____

_____

Injury or Illness requiring a hospital stay in last year _____

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

EKG DATE (Please include report) _____ **READING** _____

MEDICATION ALLERGY: _____

PLEASE LIST OR ATTACH CURRENT MEDICATIONS

Name of medication	Dosage	Route	Frequency

FOOD ALLERGY: _____

RECOMMENDED DIET: _____

Patient's Name: _____

TUBERCULOSIS SCREENING IS *REQUIRED* FOR ALL CLIENTS WHO PLAN TO TRAIN ON CAMPUS

History of positive TB test or Disease Yes____ No_____

If yes, a symptom review and chest-xray (if none performed if the previous year) should be performed.
If no, continue with questions below.

If there is a "YES" response to any of the questions 1-5, then a tuberculin skin test (TST/ PPD) or QuantiFERON Gold test should be performed, and results entered below.

Risk Factors	
1. One or more signs and symptoms of TB (prolonged cough, coughing up blood, fever, night sweats, weight loss, excessive fatigue) Note: A chest x-ray and/or sputum examination may be necessary to rule out infectious TB.[2]	Yes ☐ No ☐
2. Close contact with someone with infectious TB disease	Yes ☐ No ☐
3. Birth in high TB-prevalence country** (**Any country other than the United States, Canada, Australia, New Zealand, or a country in Western or Northern Europe.)	Yes ☐ No ☐
4. Travel to high TB-prevalence country** for more than 1 month (**Any country other than the United States, Canada, Australia, New Zealand, or a country in Western or Northern Europe.)	Yes ☐ No ☐
5. Current or former residence or work in a correctional facility, long-term care facility, hospital, or homeless shelter	Yes ☐ No ☐

**Once a person has a documented positive test for TB infection that has been followed by an x-ray that was deemed free of infectious TB, the TB risk assessment is no longer required.*

TUBERCULOSIS TEST (IF YES TO ANY OF THE ABOVE RISK ASSESSMENT)

DATE GIVEN _____ **RESULT** _____

POSITIVE RESULT - INCLUDE CHEST X-RAY **DATE** _____ **READING** _____

FOR DIABETIC PATIENTS

DOES THIS PATIENT CONSISTENTLY COMPLY WITH:

☐ BLOOD SUGAR TESTING ☐ INSULIN ADMINISTRATION ☐ INSULIN PUMP

☐ DIETARY RESTRICTIONS ☐ ROUTINE FOOT CARE ☐ SLIDING SCALE

IS THIS PATIENT ABLE TO:

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

A1C BLOOD LEVEL (DATE): _____

FREQUENCY OF HYPOGLYCEMIC OR HYPERGLYCEMIC REACTIONS: _____

Patient's Name: _____

Your patient has applied to our school for a guide dog. Guiding Eyes for the Blind's two/three-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 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, clients 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. 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 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** _____