Paws For Life USA, Inc Client Application Part B Medical History Form

Please ask your Doctor to complete this form. Sign the release below and ask your physician to return it directly to Paws For Life USA.

Patient's Last name _____ First _____ Sex: ___ Date of Birth _____

Release of Medical Information

This authorizes you to release information regarding my condition to Paws For Life USA, Inc. This information will be used to evaluate and assess my situation and is essential for PFL USA to train myself and my service dog to increase my independence. All information is confidential.

Parental or duly authorized consent is required, pursuant to State and Federal law, if client is a minor, or under guardianship or conservatorship/ward of the court.

Printed name _____ Date _____

Signature _____

Guardian _____

Relationship or title and agency

_____

Agency address and phone number

_____

_____

_____

To the Doctor or Psychiatrist:

We maintain confidentiality of our clients' records. What you write here will not be shared with your patient unless you give express permission. All information provided will remain the property of PFL USA.

If you have questions, please contact Paws For Life USA, Inc. at (770) 402-0297. Please mail the completed form to:

Paws For Life USA, Inc.
P.O. Box 72016
Marietta, GA 30007-2016
or fax to (770) 579-8289

Practitioner's Name: _____ Specialty: _____

Address: _____

Telephone: _____ Fax: _____

Date of last examination: _____ Length of association with patient: _____

What is patient's primary diagnosis? ________

What other conditions/diagnoses does the patient have? _____

_____

Prognosis for duration of impairment(s):

_____

Prognosis for progression of impairment(s):

_____

Prognosis for lifespan:

_____

Medications taken on a regular basis (please list): _____

_____

How severe is the patient's mobility impairment? (Please circle)

None		Needs assistive devise		Needs full-time care
1	2	3	4	5

How severe is the patient's visual impairment? (PFL USA does not train dogs to for the blind.)

None/correctible with glasses		Needs assistive devise		Blind
1	2	3	4	5

How severe is the patient's auditory impairment?

None		Needs assistive devise		Deaf
1	2	3	4	5

How severe is the patient's cognitive impairment?

None		Often needs assistance		Needs full-time care
1	2	3	4	5

Do limitations affect patient's ability to control his/her own behavior?

Normal		Moderate		Poor self-control
1	2	3	4	5

How effective is the patient at handling and overcoming their limitations?

Ineffective		Moderate		Very competent
1	2	3	4	5

How reliable is the patient – on time for appointments, compliant with medications, etc?

Unreliable		Moderate		Very reliable
1	2	3	4	5

To what degree do limitations affect patient's ability to perform Activities of Daily Living* (ADL):

Normal		Moderate		Totally reliant
1	2	3	4	5

* Activities of Daily Living (ADL) refers to the ability to meet personal care needs, i.e. feeding, bathing, dressing, etc., as well as the ability to perform tasks necessary for independent living, i.e., be compliant with therapy and medications, manage finances, maintain home, acquire outside services.

Cognitive and Emotional Evaluation of Patient:	**Yes**	**Minimally**	**No**
A. Able to exercise judgment and make decisions necessary for ADL	___	____	___
B. Able to sustain attention span	___	____	___
C. Manifesting inappropriate behavior beyond his/her control	___	____	___
D. Able to control physical or motor movement sufficient to sustain ADL	___	____	___
E. Capable of perception and memory to the degree necessary to sustain ADL	___	____	___
F. Able to follow directions and learn to the degree necessary to sustain ADL	___	____	___
G. Under medication which impairs functioning	___	____	___
H. Capable of decisions about personal and others' needs and safety	___	____	___

Is incapacity due to or affected by patient's alcoholism or drug abuse? ❑ Yes ❑ No

IF YES:

A. Has patient ever been in treatment facility? ❑ Yes ❑ No

If yes, when and duration? _____

B. Has permanent damage resulted? ❑ Yes ❑ No

C. Has patient refused treatment or referral to a treatment center? ❑ Yes ❑ No

Paws For Life USA's Dogs may be skilled at the following tasks:

- Manners and obedience
- Retrieve dropped articles
- Push Lifeline or 911 button
- Find and retrieve phone
- Find help
- Retrieve from refrigerator
- Push handicap buttons
- Turn lights off and on
- Open and close doors
- Enhance balance while walking
- Enhance balance while going up or down stairs
- Provide brace for transfers or getting up from floor/chair
- Assist in pulling wheelchair
- Retrieve adaptive equipment
- Carry items in mouth or backpacks
- Take items to another person
- Specialized tasks as needed by client; e.g., assist with laundry, get the mail, tug shoes or coat off

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Paws For Life USA dogs will be task trained to alert and assist with their handlers disability together with achieving their Public Access Test if trained for service. No PAT is required for ESA. Your patient will gain some independence and their care givers some assistance providing an increase in quality of life.

Are there other ways in which you think your patient would benefit from receiving an PFL dog? If so, please describe:

_____

_____

_____

Can you recommend that this patient receive an PFL USA dog? ❑ Yes ❑ No

Why or Why Not? _____

_____

May we contact you with questions? ❑ No ❑ Yes If no can you explain why?

Additional Comments or Remarks: _____

_____

_____

_____

Signature of physician or therapist: _____ **Date: _____**

Mail to: Paws For Life USA, Inc
P.O. Box 72016
Marietta, GA 30007-2016
Fax to: 770-579-8289
Call: 770-402-0297
www.pawsforlifeusa.org
Email: Admin@PawsForLifeUSA.Org