

PAWS FOR LIFE USA	Psychiatric Service Dog  Mental Health Form	
--------------------------------------	--	---

Dear Provider,

Your patient _____ DOB: _____ has applied to
(name of patient)

Paws For Life USA psychiatric / PTSD required form for a Service Dog, Your patient has completed the attached Consent Form which authorizes you to share information in regards to your patients psychiatric / PTSD and/or other related diagnosis mental health in relationship to our service dog program.

In order for us to consider their application can you please provide us with the information requested in this Mental Health Form.

All of the psychiatric / PTSD applicants in our Paws For Life USA program must provide us with written information confirming their diagnosis from a psychiatrist or psychologist qualified to make the diagnosis.

Date of Mental Health Diagnosis: _____

Diagnosed by: _____

Qualifications: _____

The following is to be completed by the Patients Mental Health Provider (Psychotherapist, MHY Nurse, Registered Social Worker, VA or other qualified professional with experience in Psychiatric / PTSD or Mental Health).

Providing us with information will help us to “Custom” our support to our client and increase our understanding of the specific disabilities that they have.

Our program is challenging for some and it means a commitment to attend training on a regular basis, either in person or virtual, more so in the early stages of training, but as disabilities vacillate, basically it will be for the working life of the dog. With the first 2 years being predominantly the hardest challenge for the team.

Paws For Life USA has a 24/7 commitment to the working life of the service dog to be there for the team, to encourage and provide the support needed, with the objective of gaining independence, the ability to feel secure and be able to socialize in today's environment.

Paws For Life USA strides for a successful partnership with our dog placements. Therefore, we ask that you complete this report **and summarize the state of the applicant's** mental health and treatment. If you have any questions about our program, please contact Mike Alexander or Kimberly Brenowitz at Admin@pawsforlifeusa.org.

Paws For Life USA, a 501c3 non-profit

Cell: 770-402-0297 Fax: 770-579-8289 Tax ID#: 86-1094919

Mailing Address: P.O. Box 72016, Marietta, Georgia 30007-2016

School Address: 3100 Roswell Road, Ste 125, Marietta, GA 30062

Web Site: <https://www.PawsForLifeUSA.org>

Like us on Facebook: <https://www.facebook.com/pawsforlifeusa>

MENTAL HEALTH REPORT

Please indicate any disorders experience by your patient:

Military Service-Connected Post Traumatic Post Traumatic Stress Disorder please note if chronic	
Obsessive Compulsive Disorder	
Military Sexual Trauma	
Non-Military Service-Connected Post Traumatic Stress Disorder please note if chronic	
Bi-Polar	
Schizoid Personality Disorder	
Delusional Disorder	
Panic Disorder	

ADHD	
Depression	
General Anxiety	
Borderline Personality Disorder	
Paranoid Personality Disorder	
Schizophrenia	
Anti-Social Personality Disorder	
Multiple Personality Disorder please not if chronic	
Suicidal Ideation and / or any attempts? If so last date of attempt.	
Alcohol or Drug Abuse	
Triggers: Sight, Hearing, Touch, Taste or Smell	
Disassociation	

Is your patient currently receiving psychiatric treatment or counseling? _____

Please list any medications currently being taken by your patient and its purpose:	
Rx	
Rx	
Rx	
Rx	
Rx	

ANGER MANAGEMENT / STRESS / SUICIDAL IDEATION

Does your patient have **anger management** issues? _____

For Military - Out of combat has your patient ever harmed another person? _____

For Non-Military has your patient ever harmed another person? _____

Does your patient have problems with their ADL's? _____

Has your patient ever harmed an animal? _____

In your opinion how does your patient respond to the challenge of managing and interacting with their service dog? _____

If they already have a service animal, how do they say they are managing? _____

Any other Comments or Notes that we should be made Aware of as it relates to your Patient having the responsibility of a service animal? ☐ No ☐ Yes

Does your patient recognize signs of stress in their service animal? ☐ No ☐ Yes

Please describe your patient's anger management and / or frustration tolerance skills.

Please provide any additional information related to your assessment of your patient's suicidal ideation planned or intent, if applicable.

Does your patient have the ability to recognize when they become overwhelmed and will they seek professional help to manage their emotions and improve the handler / service animal relationship? ☐ No ☐ Yes

In your opinion can your patient provide the care and training necessary to properly care for a service animal? ☐ No ☐ Yes

PLEASE RETURN THIS COMPLETED MENTAL HEALTH FORM EITHER BY MAIL or EMAIL TO PAWS FOR LIFE USA Admin@pawsforlifeusa.org or Fax 770-579-8289

Provider Signature - I hereby certify that all information provided is true, to the best of my knowledge*

_____ Date: _____

Your professional Title: _____

Name of Practice: _____

Address of Practice: _____

**Mail to: Paws For Life USA
P.O. Box 72016
Marietta, GA 30007-2016**

OR Fax to: 770-579-8289

**OR For questions
Call or Text: 770-402-0297**

Thank you Paws For Life USA