# Medical History Form For Service Dog Application

Canines for Service partners service dogs for Veterans with PTSD, MST, TBI, and/or Mobility Limitations. The Applicant listed below is applying to receive a service dog from our program. Please complete the information below to the best of your professional judgement. This form **IS NOT** an endorsement for the applicant to be approved, but gives Canines For Service an opportunity to evaluate the applicant's medical history to ensure a service dog from our program is capable of assisting them effectively.

***The completed medical history form should be mailed or emailed to:***

**Ellie Gardner**
**221-1 Old Dairy, Wilmington, NC 28405 or**
**egardner@caninesforservice.org**

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## Authorization For Release Of Information

*(To be completed by the applicant)*

**Date**:

**Dr.**

I authorize my provider to discuss the protected health information provided below with Canines for Service. This authorization expires upon my withdrawal from the Canines for Service program or, if approved, upon the retirement of my last service dog received from the program.

**Applicant's Name (please print):**

**Applicant's Signature:**

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## Physician Information

*(The remainder of the form to be completed by the physician)*

**Physician Practice Name:**

**Physician Name:**

**License Type:** **License #:**

**Address:**
**City:** **State:** **Zip:**

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**Telephone:**

**Email:**

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## Patient Information

**Full Name:**

**Date of Birth:**

**Date of Last Exam/Visit:**

**How long has the patient been under your care?** **Yrs** **Mos**

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## Health Overview

**Does the patient have a history of the following (check all that apply):**

- ☐ *Asthma*
- ☐ *Heart Attack*
- ☐ *Seizures*
- ☐ *Stroke*
- ☐ *Lung Disease*
- ☐ *Hypertension*
- ☐ *Memory Loss*
- ☐ *Mobility*
- ☐ *Hearing Loss*
- ☐ *Vision Impairment*
- ☐ *Muscular Weakness*
- ☐ *Balance Issues*
- ☐ *Other:*

**Patient's Primary Diagnosis (ICD code and description):**

**Secondary Diagnoses (ICD code and description):**

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**Date of Onset:**

**Current Treatment Plan:**

**Prognosis (E.G. stable, progressive, improving) :**

**Does the patient have any physical limitations?**

- ☐ *Difficulty standing for extended periods of time*
- ☐ *Difficulty with fine motor tasks*
- ☐ *Difficulty with balance/gait*
- ☐ *Difficulty with transfers (chair to standing)*
- ☐ *Difficulty using stairs*
- ☐ *Limited endurance (please specify duration):*
- ☐ *Requires assistance device (cane, walker, etc.):*

## Mental Health

**Does the patient have any of the following psychological conditions or disorders? (Check all that apply)**

- ☐ *Anxiety*
- ☐ *Bipolar*
- ☐ *Depression*
- ☐ *Obsessive Compulsive Disorder*
- ☐ *Panic Disorder*
- ☐ *Agoraphobia*
- ☐ *Schizophrenia*
- ☐ *Post Traumatic Stress Disorder*
- ☐ *Social Phobia*
- ☐ *Other:*
- ☐ *Unknown*

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**Does the patient experience any of the following symptoms due to a psychological condition or disorder? (Check all that apply)**

- ☐ *Anger*
- ☐ *Disorientation*
- ☐ *Moodiness*
- ☐ *Nightmares*
- ☐ *Sadness*
- ☐ *Other:*
- ☐ *Unknown*
- ☐ *Apathy*
- ☐ *Fearfulness*
- ☐ *Insomnia/Difficulty Sleeping*
- ☐ *Panic*
- ☐ *Social Withdrawal*
- ☐ *Crying*
- ☐ *Forgetfulness*
- ☐ *Nervousness*
- ☐ *Restlessness*

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**Is the patient physically capable of handling a large service dog between 60-80 lbs?**

◯ **Yes** ◯ **No**

**Do you believe the patient would benefit from having a service dog?**

◯ **Yes** ◯ **No**

**How do you feel the individual would or would not benefit from having a service dog:**

**Please provide any supplemental documentation that supports the patient's diagnosis is service connected.**

**Provider Signature:** **Date:**