APPLICATION FOR SERVICE DOG

Medical History

To be completed by Primary Care Physician and returned to K9s For Camo

Physician's Release:

Name of Doctor:____

Please release the requested medical information regarding my condition to K9s For Camo. This information will be used to help the organization determine my abilities to obtain a service dog. Thank you.

Applicant Name (please print):____

Applicant Signature: ____Date:__________________

Physician Contact Information

Doctor/Therapist Name:		Specialty:
Address:		
City:	State:	Zip:
Phone:	Fax:	

Patient Status

Define primary disability:

Cause of disability:

Are there significant secondary disabilities? If yes, please describe:

At what age was the patient disabled? ________ Is the disability progressive? (Circle) Yes No

Is there an incapacity due to drug or alcohol abuse? (Circle) Yes No

Effects of Victim's Disability (Please check all that apply)

Muscular Weakness ( )	Vision Impairment ( )	Memory Loss ( )	Hearing ( )
Coordination Problems ( )	Speech Impairment ( )	Limited Mobility ( )	Deafness ( )
Delayed Development ( )	Reduced Stamina ( )	Spasticity ( )	None ( )

Other:

Side Effects (Please check all that apply)

Heat/Cold Sensitive ( )	Balance ( )	Depression ( )	Allergies ( )	Anger ( )
Heightened Emotions ( )	Seizures ( )	Brittle Bones ( )	Chronic Pain ( )	Other:

Equipment Required (Please check all that apply)

Wheelchair:	Manual ( )	Power ( )	Both ( )
Crutches ( )	Hearing Aid ( )	Cane ( )	Prosthesis ( )
Wrist Braces ( )	Walker ( )	3-Wheel Electric Scooter ( )	Leg Brace ( )

Other:

Activity of Daily Living (Please check all that apply)

	Yes	No	Slight
Able to sustain attention span			
Manifesting inappropriate behavior beyond his or her control			
Able to control physical and motor movement sufficient to sustain ADL			
Able to exercise judgment to make decisions necessary for ADL			
Capable of perception and memory to sustain ADL			
Able to follow directions and learn to a degree necessary for ADL			
Under medication which impairs physical or mental functioning			
Capable of decisions concerning self and others' needs and safety			

Overall Patient Assessment

Would you recommend this individual for a K9s For Camo service dog? (Please circle) Yes No

Do you think K9s For Camo would benefit from a consultation with you to help facilitate placement of a service dog? (Please circle) Yes No

Do you think this individual has the ability to care for a dog or implement the help necessary to care for a service dog? (Please circle) Yes No

Physician's Signature ____Date:________________

Please return the completed Medical History forms to:

K9s For Camo
Attention: Application for Service Dog
2733 E Battlefield St #125
Springfield, MO 65804