PHYSICIAN INFORMATION FORM

This form is to be completed by your or your child's physician and sent by him/her directly back to EENP by mail. Please sign the release (below) before giving the form to physician.

Dr. ____

Please release the requested information to Eyes Ears Nose and Paws, Inc. regarding the condition of

☐ myself ☐ my child ____ (print name here).

This information will help determine my situation in regard to the placement of an assistance dog.

____

Applicant or Guardian Name (please print)

____

Applicant or Guardian Signature Date

PATIENT INFORMATION

What is this patient's primary disability? ____

____

Cause of disability and how it came about (example - spinal cord injury due to auto accident):

____

____

At what age was (s)he disabled? ____

Is this disability progressive? ____

Please list additional disabilities/medical conditions: __________________________________

____

____

Current number of hours of attendant care per week: _________________________________

Is there an incapacity due to or affected by alcoholism or drug abuse? ___________________

Medical Emergencies: ***(please check all that apply)***

___Required *medical* assistance (from EMT, hospitalization, etc.) _____ times in the past year due to a medical event related to disability/medical condition.

___Required help from personal support (parent, spouse, etc.) _____ times in the past year due to a medical event related to disability/medical condition.

If patient has diabetes: last A1C level ______ date taken ______

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IMPAIRMENT MEASUREMENT

Please rate the severity of the following impairments and conditions using this scale:

0 = no impairment	***1 = mild***	***2 = moderate***	***3 = severe***

I. Motor impairments

Weakness	0	1	2	3
Coordination	0	1	2	3
Spasticity	0	1	2	3

II. Sensory impairments

Vision	0	1	2	3
Hearing	0	1	2	3
Loss of sensation	0	1	2	3

III. Cognitive impairments

Attention	0	1	2	3
Memory	0	1	2	3
Problem solving	0	1	2	3
Judgment	0	1	2	3

IV. Communication impairments

Comprehension	0	1	2	3
Expression	0	1	2	3

V. Psychological/behavioral descriptions

Depressed	0	1	2	3
Difficulties managing stress	0	1	2	3
Impulsive	0	1	2	3
Inappropriate	0	1	2	3

VI. Additional medical conditions

Cardiovascular disease	0	1	2	3
Respiratory disease	0	1	2	3
Diabetes	0	1	2	3
Seizure disorder	0	1	2	3
Chronic pain	0	1	2	3
Neurogenic bladder	0	1	2	3
Neurogenic bowel	0	1	2	3

Please list other medical conditions:

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PHYSICAL INDEPENDENCE AND LOCOMOTION

Please identify Functional Independence Measure (FIM) levels for the following motor activities using this scale:

NO HELPER
7 = Complete independence (timely, safely)
6 = Modified independence (device)
HELPER – MODIFIED INDEPENDENCE
5 = Supervision
4 = Minimal assistance (can perform 75% of activity)
3 = Moderate assistance (can perform 50% of activity)
HELPER – COMPLETE DEPENDENCE
2 = Maximal assistance (can perform 25% of activity)
1 =Total assistance (can perform 0% of the activity)

__ Patient is completely independent in all areas of self-care *(if so, skip to "locomotion")*

Self-Care

Eating	1	2	3	4	5	6	7
Grooming	1	2	3	4	5	6	7
Bathing	1	2	3	4	5	6	7
Dressing-upper body	1	2	3	4	5	6	7
Dressing-lower body	1	2	3	4	5	6	7
Toileting	1	2	3	4	5	6	7

Sphincter Control

Bladder management	1	2	3	4	5	6	7
Bowel management	1	2	3	4	5	6	7

Transfers

Chair, wheelchair	1	2	3	4	5	6	7
Toilet	1	2	3	4	5	6	7
Tub, shower	1	2	3	4	5	6	7

Locomotion

__ Patient does not use an assistive device for walking *(if so, skip to next section)*

__ Patient uses the following during a typical day: *(please check all that apply)*

☐ Walk without assistive device sometimes ☐ Cane ☐ Walker ☐ Crutches

☐ Manual Wheelchair ☐ Power wheelchair / Scooter ☐ Prosthesis ☐ Brace

☐ Other Assistive devices (please list): ___________________________________

PHYSICIAN INFORMATION

Physician Name ____

Type of Practice ____

Street Address ____

____

Phone ____________________________________ **Fax** ________________________________

Email ____

Can you recommend this individual for an assistance dog? _________________________

Comments:

____

Physician's Signature Print Name Date

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Eyes Ears Nose & Paws
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Chapel Hill, NC 27515

We do not have a fax machine. For questions, call us at 919-408-7292.