

CLIENT APPLICATION AND MEDICAL HISTORY - VETERAN

LOVING ANGEL SERVICE DOGS, INC.

PLEASE PRINT CLEARLY

DATE _____

Are you a veteran? ☐ Yes ☐ No What branch of the military? _____

Are you active or retired? _____ Dates of Service _____

First Name _____ Last Name _____

Street Address _____

City _____ State _____ Zip _____

Home Phone _____ Cell Phone _____

E-Mail _____

Date of birth (mm/dd/yyyy) _____ Age _____ Gender ☐ M ☐ F

Approximate weight _____ Approximate height _____

Marital status ☐ Single ☐ Married ☐ Divorced ☐ Separated

Employer _____ Work Phone _____

Spouse Name _____

Nearest Relative Name _____ How Related _____

Street Address _____

City _____ State _____ Zip _____

Daytime Phone _____ Cell Phone _____

(Including Area Code)

E-Mail _____

PHYSICIAN INFORMATION

Name _____ Type of practice _____

Phone (Including area code) _____

City _____ State _____ Zip _____

Is your doctor available for a consultation regarding this application? ☐ Yes ☐ No

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DISABILITY INFORMATION

What is your primary disability? _____

Please list secondary disabilities, if any _____

What caused your disability or disabilities? _____

If caused by an injury, what progress has been made since the injury? _____

How does it affect your life (limitations)? _____

How long have you been disabled? _____

Is your disability progressive? ☐ Yes ☐ No

Are there any current changes in your disability? ☐ Yes ☐ No

If yes, explain

What are the effects of your disability? (check all that apply)

- ☐ Deafness ☐ Speech Impairment ☐ Reduced Stamina ☐ Hearing Loss ☐ Spasticity
☐ Limited Mobility ☐ Muscular Weakness ☐ Slow Development ☐ Vision Impairment
☐ Memory Loss

Explain in more detail *anything* that will better help us to understand your needs.

Do you currently receive any government benefits? ☐ Yes ☐ No

If Yes, please check all that apply:

- ☐ SSI ☐ Veterans ☐ Rehab ☐ Disability

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DOG INFORMATION

What kind of dog are you looking for?

☐ Public Access Service dog ☐ In-home skilled dog ☐ Facility dog

How do you think your dog will be able to help you? _____

What skills do you hope your dog will have? _____

Do you currently have, or have you ever had a service dog? ☐ No ☐ Current ☐ In the Past

If so, who trained your dog? _____

How many years did the dog partner with you? _____

Having a service dog is an incredible opportunity that can enhance your life in many areas – physically, emotionally, spiritually and socially. Along with those benefits come associated responsibilities. As the owner of a service dog, your team not only represents Loving Angel Service Dogs, but you are also an ambassador and a public educator on behalf of all service dogs. It is vital that you and your dog are well mannered and clean and neat when you are out in public.

Are you willing and able to assume full responsibility as caregiver for your Service Dog? This includes many areas:

Daily grooming including brushing coat and teeth. ☐ Yes ☐ No

Periodic baths and toenail trimming ☐ Yes ☐ No

Medical care as prescribed by your veterinarian ☐ Yes ☐ No

Proper feeding with a good quality dog food to maintain overall health, coat health and to maintain the dog's proper weight. ☐ Yes ☐ No

Daily exercise and playtime ☐ Yes ☐ No

You will assume full responsibility for cleaning up after your dog eliminates in public and for repairing any damage caused by your dog. ☐ Yes ☐ No

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Please describe how you will handle the following areas of dog care:

Feeding _____

Grooming _____

Exercising _____

Toileting _____

Vet Care _____

Financial Costs - yearly approximate costs: about \$2,000/year

If you are hospitalized _____

Flea problems _____

Heartworm prevention _____

Family/friend involvement _____

Access Issues _____

Dog behavior problems _____

Attending our Training Program _____

Our training program is physically and emotionally demanding. What specific difficulties might you have with it? _____

What modifications do you need to make to accommodate this training? _____

What modifications must the training program make to accommodate your specific difficulties?

How will you handle costs and time required to attend the class? _____

Are you willing and able to commit to training your dog for (3) 15 minute sessions each day while attending training classes at Loving Angel? YES _____ NO _____

Are you committed to having a successful Service Dog Partnership and so will continue training your dog daily after graduation? YES _____ NO _____

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List the **names, addresses and phone numbers** of two people who will provide letters of recommendation for you. Have them send their letters to the Executive Director at the address listed below.

1. Personal (not related to you)

2. Professional (therapist, physician, etc.)

Signature _____ Date _____

All the information I have provided is true to the best of my knowledge, up-to-date and accurate

**SEND YOUR COMPLETED APPLICATION ALONG WITH A \$40 CHECK MADE OUT TO
LOVING ANGEL SERVICE DOGS, INC.
3734 SUGAR LEO RD.
ST. GEORGE, UT 84790**

INCLUDE A COPY OF YOUR DD214

CLIENT APPLICATION AND MEDICAL HISTORY - VETERAN

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MEDICAL HISTORY FORM

PUT YOUR NAME ON EACH PAGE and sign the release below and give all four pages to your physician or therapist to complete. Ask them to return it directly to Loving Angel Service Dogs

RELEASE OF MEDICAL INFORMATION

This authorizes you to release information regarding my condition to Loving Angel Service Dogs, Inc. This information will be used to evaluate and assess my situation and is essential for Loving Angel to train a service dog to increase my independence. All information is confidential.

Name _____ Date of Birth _____

Signature

To the Physician or Therapist:

We maintain confidentiality of our clients' records. The information you give here will not be shared with your patient unless you give express permission.

If you have any questions, please contact Loving Angel Service Dogs, Inc. at (435) 632-2482

Mail the completed form to:

Executive Director
Loving Angel Service Dogs, Inc.
3734 Sugar Leo Rd.
St. George, UT 84790

LOVING ANGEL SERVICE DOGS, INC.

MEDICAL HISTORY FORM

PAGE 1

PATIENT NAME _____ DATE _____

PRACTITIONER'S NAME: _____ SPECIALTY _____

Address: _____

Phone: _____

Date of Last Exam: _____ Length of association with patient: _____

What is the primary diagnosis? _____

What other conditions 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: _____

How severe is the patient's mobility impairment?

NONE _____ NEEDS ASSISTIVE DEVICE _____ NEEDS FULL-TIME CARE _____

1 2 3 4 5

How severe is the patient's visual impairment?

NONE(correctible w/ glasses) _____ NEEDS ASSISTIVE DEVICE _____ BLIND _____

1 2 3 4 5

How severe is the patient's auditory impairment?

NONE _____ NEEDS ASSISTIVE DEVICE _____ DEAF _____

1 2 3 4 5

How severe is the patient's cognitive impairment?

NONE _____ NEEDS ASSISTIVE DEVICE _____ 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 on handling and overcoming their limitations?

VERY COMPETENT _____ MODERATE _____ INEFFECTIVE _____

1 2 3 4 5

MEDICAL HISTORY FORM

PATIENT NAME _____

1
2
3
4
5

COGNITIVE AND MENTAL EVALUATION:

Capable of decision about personal and others' needs and safety

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

Has patient refused treatment or referral to a treatment center? ☐ Yes ☐ No

LOVING ANGEL SERVICE DOGS, INC.

MEDICAL HISTORY FORM

PAGE 3

PATIENT NAME _____

Our service dogs are highly trained to assist their partners with many tasks besides being a loyal companion who gives unconditional love. Some of the tasks they may be trained to do are:

Retrieve dropped articles
Push Lifeline or 911 button
Find help
Retrieve items from refrigerator
Turn lights off and on
Open and close doors
Provide bracing for transfers

Enhance balance when walking
Enhance balance when taking the stairs
Assist in pulling wheelchair
Carry items in mouth or backpack
Take items to another person
Help undressing – shoes, socks, sweaters, etc.
Find and retrieve items like keys, etc.

Are there any other tasks that a service dog could do that your patient would benefit from?

Do you think your patient would benefit from a service dog? ☐ Yes ☐ No How? Or Why not?

Can you recommend that this patient is capable of training a Service Dog (with guidance and help from the Agency)? ☐ Yes ☐ No

Why or why not? _____

May we contact you with questions? ☐ Yes ☐ No

Best way to contact you _____

Any addition comments: _____

Signature of physician or therapist: _____ Date _____