

MEDICAL REPORT

Your patient has requested a guide dog. The duration of our course is 33 days and it is quite rigorous; it also takes place regardless of weather conditions. Could you please fill out this report so that we may adapt our training program to your patient's physical condition.

Name of patient:	Surname:
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Address:

City:	Province:	Postal code:
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Tel. (home): ()	Tel. (bus.): ()
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Does your patient have or has he (she) had one or more of the following problems:

<input type="checkbox"/> Loss of hearing	<input type="checkbox"/> Rheumatism or arthritis
<input type="checkbox"/> Convulsion attacks, loss of consciousness, dizziness	<input type="checkbox"/> Asthma
<input type="checkbox"/> Orthopedic problems	<input type="checkbox"/> Cancer
<input type="checkbox"/> Nervous system problems	<input type="checkbox"/> Hernia
<input type="checkbox"/> Paralysis	<input type="checkbox"/> Tuberculosis
<input type="checkbox"/> Loss of balance	<input type="checkbox"/> Serious injuries
<input type="checkbox"/> Epilepsy	<input type="checkbox"/> Circulatory problems
<input type="checkbox"/> Coordination	<input type="checkbox"/> Other physical problems
<input type="checkbox"/> Emotional problems	<input type="checkbox"/> Kidney or urinary problems
<input type="checkbox"/> Digestive problems (If so, please see page attached)	<input type="checkbox"/> Hepatitis
<input type="checkbox"/> Nervous problems	<input type="checkbox"/> HIV
<input type="checkbox"/> Allergies	<input type="checkbox"/> Other

Comments on any of the above conditions:

Cause of blindness:	Remaining sight:
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Please describe any pulmonary problems:

Please describe any cardiac problems, hypertension or cerebro-vascular accident:

Please describe any special diet or medication taken, including the daily dosages:

Date

Treating Doctor

FOR DIABETIC PATIENT

Diet:

Calories per day:

Oral medication:

Daily dosage :

Insulin

Insulin

Dosage (a.m.):

Dosage (p.m.):

Does the patient inject himself (herself) ? Yes No

Does the patient measure the insulin himself (herself) ? Yes No

Does the patient adjust his (her) dose of insulin on his (her) own? Yes No

Does the patient check his (her) sugar level on his (her) own ? Yes No

Method used to check sugar level:

Date and report of last glycaemia check:

Date and consequences of the most recent diabetic coma or hypoglycaemic shock:

Secondary complications (neuropathic – nephropathic) or instructions/comments:

Date of the exam on which this report was based:

Date

Treating Doctor