Standard Poodles of Service

An applicant of Standard Poodles of Service (SPoS) has listed you as their Medical Reference. Please complete this form to the best of your ability. SPoS maintains the confidentiality of our applicants' records. What you write here will not be shared with your patient unless you give express written permission. If you have questions, please contact the Client Services Team of SPoS at (888) 558-8084.

Patient's Information

First Name _____ **Last Name** _____

Date of Birth _____

Gender:

- ○ Male
- ○ Female
- ○ Non-binary
- ○ Other

Date of Last Examination or Session _____

Length of Association with Practitioner (years, months) _____

Release of Medical Information

I, the applicant, authorize my medical provider to release informaAon regarding my condiAon to Standard Poodles of Service (SPoS). This informaAon will be used to evaluate and assess my situaAon and is essenAal for FSD to train a service dog to increase my independence. All informaAon is confidenAal.I understand that I am solely responsible for ensuring that this Medical History form is given to my medical provider, and that said provider supplies the completed form to SPoS.

Parental or duly authorized consent is required, pursuant to state and federal law, if the applicant is a minor or under guardianship or conservatorship/ward of the court.

Print Full Name _____

Signature _____ **Date** _____

Practitioner's Information

First Name _____ **Last Name** _____

Specialty _____

Phone Number _____

Email _____

Address _____

City _____ **State** _____

Zip Code _____

Patient Military Affiliation

- ○ Active Duty
- ○ Veteran
- ○ Civilian

Patient Diagnosis

Patient's Primary Diagnosis _____

Other Conditions/Diagnoses _____

_____

Prognosis for Duration of Impairment_____

Prognosis for Progression of Impairment_____

_____

Prognosis for Lifespan _____

Medications Taken on a Regular Basis (please list) _____

_____

Cognitive and Emotional Evaluation of Patient

A. Able to exercise judgement and make decisions necessary for Activities of Daily Living (ADL)

- ○ Yes
- ○ Minimally
- ○ No

B. Able to sustain attention span

- ○ Yes
- ○ Minimally
- ○ No

C. Manifests inappropriate behavior beyond his/her control

- ○ Yes
- ○ Minimally
- ○ No

D. Able to control physical or motor movement sufficient to sustain ADL

- ○ Yes
- ○ Minimally
- ○ No

E. Capable of perception and memory to the degree necessary to sustain ADL

- ○ Yes
- ○ Minimally
- ○ No

F. Able to follow directions and learn to the degree necessary to sustain ADL

- ○ Yes
- ○ Minimally
- ○ No

G. Under medication which impairs functioning

- ○ Yes
- ○ Minimally
- ○ No

H. Capable of decisions about personal and others' needs and safety

- ○ Yes
- ○ Minimally
- ○ No

Overall Evaluation of Patient

How severe is the patients mobility impairment?

O	O	O	O	O
1 - None	2	3 - Needs assistive device	4	5 - Needs full-time care

How severe is the patient's visual impairment?

O	O	O	O	O
1 - None	2	3 - Needs assistive device	4	5 - Needs full-time care

How severe is the patient's auditory impairment?

O	O	O	O	O
1 - None	2	3 - Needs assistive device	4	5 - Needs full-time care

How severe is the patient's cognitive impairment?

O	O	O	O	O
1 - None	2	3 - Moderate	4	5 - Needs full-time care

How well is the patient able to control his/her own behavior?

O	O	O	O	O
1 - Very Well	2	3 - Average	4	5 - Very Poor

How effective is the patient at handling and overcoming their limitations?

O	O	O	O	O
1 - Very Effective	2	3 - Average	4	5 - Very Ineffective

How reliable is the patient - on time for appointments, compliant with medications, etc?

O	O	O	O	O
1 - Very Reliable	2	3 - Average	4	5 - Very Unreliable

Alcoholism or Drug Abuse

Is any incapacity due to or affected by the patient's alcoholism or drug abuse?

O Yes
O No

If Yes, please explain _____

Service Animal Details

In what ways do you envision the patient benefiting from or utilizing a service dog?

_____

_____

_____

_____

_____

_____

_____

_____

Did the patient consult with you prior to initiating their application for a service dog?

- ○ Yes
- ○ No

Would you recommend that this patient receive a service dog?

- ○ Yes
- ○ No

Why or why not? _____

Do you feel that the client is capable of properly caring for a service dog? This would include the daily physical needs of the dog, as well as the financial commitment (estimated at $2000 per year) that a service dog requires.

- ○ Yes
- ○ No

May we contact you with further questions?

- ○ Yes
- ○ No

Additional information required for Veteran and Active Duty Military applicants only. Practitioners, please complete the following section if the applicant is a Veteran or Active Duty Military.

Please describe all treatment the applicant has received related to their PTSD diagnosis

_____

_____

_____

_____

_____

Is the applicant actively suicidal?

- ○ Yes
- ○ No

Has the applicant attempted suicide in the past or expressed thoughts of suicide?

- ○ Yes
- ○ No

If yes, please explain _____

_____

Please describe how the applicant copes with their anger and elaborate if they have any history of anger management issues

_____

_____

_____

_____

_____

Additional Comments or Remarks

_____

_____

_____

_____

_____

_____

_____

_____

Submission Instructions

For medical professionals only.

If you have any questions, please contact Standard Poodles of Service at (888) 558-8084. Unfortunately, we do not have fax available at this time. Please forward the completed and signed form to one of the following:

Email: **freedom@standardpoodlesofservice.com**

By Mail: Standard Poodles of Service
3470 Clamdara Ave
Las Vegas NV 89121

Signature of Physician or Therapist

Print Full Name _____

Signature _____ **Date** _____