SPECIAL SKILLS DOGS OF CANADA
SEIZURE RESPONSE DOG
MEDICAL INFORMATION
To be completed by your physician
Please print or type

Date ____________________________________

Applicant's name ____

Please release to Special Skills Dogs of Canada information regarding my health. This information will only be used to evaluate my situation in making a successful canine placement and will be respected by Special Skills Dogs of Canada as confidential medical information.

______________________________________ ________________________
APPLICANT'S SIGNATURE DATE

Or

_______________________________________ _______________________
SIGNATURE OF PARENT/LEGAL GUARDIAN, OR POWER OF ATTORNEY DATE

Physician's name: ____

Physician's speciality: ____

Address: ____

Province: __________________________ Postal Code: ________________________

Telephone: ____

MEDICAL INFORMATION

Diagnosis of patient's disability. (Continue on reverse if necessary)

Primary ____

Describe disability ____

____

____

Secondary ____

Describe disability ____

____

____

Explain limitations and additional pertinent information ______________________________

____

____

Are two or more limbs impaired? ____________________ Explain _______________________

____

Prognosis and effect of the condition on the individuals ability to perform Activities of Daily Living (ADL).____

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Please list all medications currently being taken by your patient.

MEDICATION	DOSAGE	CONDITION OR ILLNESS	SIDE EFFECTS EXPERIENCED BY YOUR PATIENT	SELF ADMINISTERED (YES OR NO)

Is your patient affected by any of the following?

Heart disease ____	Cancer ____	High blood pressure ____
Rheumatic fever ____	Diabetes ____	Infantile paralysis ____
Impaired hearing ____	HIV ____	Nervous disorders ____
Impaired sight ____	Stroke ____	Convulsive seizures ____
Epilepsy ____	Hernia ____	Fainting spells ____
Allergies ____	Polio ____	Limited mobility ____
Memory loss ____	Asthma ____	Coordination problems ____
Reduced stamina ____	Spasticity ____	Muscular weakness ____
Chronic pain ____	Depression ____	Skin sensitivity ____
Brittle bones ____	Imbalance ____	Speech impediment ____

Does your patient		1=LOW, 10=HIGH
a)	Exercise judgement and make decisions necessary for ADL?	
b)	Have sufficient perception and memory to sustain ADL?	
c)	Have the ability to follow directions to learn necessary ADL?	
d)	Have the ability to make decisions for own or other's needs and safety?	

Comments: ____

____

PHYSICIAN'S SIGNATURE ____

DATE ____

SPECIAL SKILLS DOGS OF CANADA
SEIZURE RESPONSE DOG
NEUROLOGICAL INFORMATION
To be completed by your Neurologist
Please print or type

Date ____________________________________

Applicant's name ____

Special Skills Dogs of Canada requires information regarding my health, including Clinic Letters, EEG and MRI reports, as well as my permission for Special Skills Dogs of Canada to contact my neurologist to discuss my medical history. I understand this information will only be used to evaluate my situation in making a successful canine placement and will be respected by Special Skills Dogs of Canada as confidential medical information. I hereby agree to release the aforementioned items to Special Skills Dogs of Canada.

______________________________________ ________________________

APPLICANT'S SIGNATURE DATE

Or

_______________________________________ _______________________

SIGNATURE OF PARENT/LEGAL GUARDIAN, OR POWER OF ATTORNEY DATE

Neurologist's name: ____

Neurologist's speciality: ____

Address: ____

Province: __________________________ Postal Code: ________________________

Telephone: ____

____

Neurologists Signature