This form is to be completed by your physician and sent with your completed application materials to Hearts of Gold.

Information Release

I, _____, authorize Dr. _____ to release the requested medical information regarding my condition to the Hearts of Gold organization. This information will be used to help determine my abilities in regards to qualification and placement of a Service Dog.		
Applicant Printed Name:	Applicant Signature:	Date:

Doctor's Printed Name:	Type of Practice:	Street Address:
City:	State:	Zip:
Phone:	Fax:	Email:

Patient Information

Approx. Height of Applicant:	Approx. Weight of Applicant:	Applicant's Age:
Applicant's Gender:	Applicant's Primary Disability:	How long have you been treating this patient?
Are there any significant secondary disabilities? If yes, please explain:		
At what age did the applicant become disabled?	Is the disability progressive?	Is the disability or incapacitation due to alcohol/drug abuse?

Please circle all that apply.

The effects of the applicant's disabilities include:		
Altered or Unpredictable Fight or Flight Response	Blackout or Fainting spells	Chronic Pain
Coordination Problems	Decreased Concentration	Decreased Impulse Control
Delayed Development	Dissociative Episodes	Hearing Impairment
Impeded Social Function	Inability to Differentiate Fact Versus Fiction in Day to Day Life	Inability to Perform Activities of Daily Life
Learning Impairment	Limited Mobility	Memory Loss
Muscular Weakness	Reduced Stamina	Spasticity
Uncontrollable Changes in Personality	Uncontrollable and/or Unpredictable Anger Outbursts	Vision Impairment
Other:		

Please circle all that apply.

The applicant has trouble or difficulty with:		
Allergies	Balance	Brittle Bones
Caring for his or herself	Chronic Pain	Depression
Driving or Riding Public Transportation	Heat/Cold Sensitivity	Heightened Emotions
Household Chores	Seizures	Social Interactions
Other:		

Please circle all that apply.

The applicant uses any combination of the following aids or assistive devices:		
Assisted Lifting Device	Brace: Leg / Arm / Other	CPAP
Crutch(es) / Cane	Elimination Bag	Feeding Tube
Hearing Aid	Prosthesis	Stair Lift
Walker	Wheelchair (Electric)	Wheelchair (Manual)
Other:		

Is this patient:			
Able to exercise judgment and make decisions regarding ADL?	Yes	minimally	No
Able to sustain an attention span?	Yes	minimally	No
Manifesting inappropriate behavior beyond his/her control?	Yes	minimally	No
Able to control physical and motor movement sufficient to sustain ADL?	Yes	minimally	No
Capable of perception and memory to the degree necessary to sustain ADL?	Yes	minimally	No
Able to follow directions and learn to the degree necessary to sustain ADL?	Yes	minimally	No
Under medication which impairs physical or mental functioning?	Yes	minimally	No
Capable of decisions concerning self and others needs and safety?	Yes	minimally	No

How do you think a Service Dog will impact the applicant's life?		
What disability mitigating task(s) do you think the applicant would benefit from the most?		
Can you recommend this individual for a Service Dog?	Yes	No
If no, why not?		
Do you think the applicant would be better suited for an Emotional Support Animal (ESA) which would not have public access?	Yes	No
Do you feel this program might benefit from a consultation with you?	Yes	No

Doctor's Signature:	Doctor's Printed Name:	Date: