Medical Reference Form

Applicant Medical Form		
Applicants Name:	Date:	
Practitioners Name:		
Practitioner Type:		
Applicant has been a patient since:		
Applicants health/condition is stable:	YES	NO
Applicant is taking all measures required to maintain condition(s)	YES	NO
Applicant (or guardian) is capable of caring for a dog	YES	NO
Applicants condition causing need for assistance dog is long term	YES	NO
An assistance dog would be an appropriate and effective resource to mitigate the condition(s)?	YES	NO
1. Condition:		Since:
Treatment(s):		
2. Condition:		Since:
Treatment(s):		
3. Condition:		Since:
Treatment(s):		
4. Condition:		Since:
Treatment(s):		
Does the applicant have any conditions that may be contraindicated for utilizing a dog? Explain if applicable.		
Please describe how the applicants condition(s) could be mitigated by an assistance dog.		
The medical practitioner and Applicant consents to Leash of Hope being in contact with this medical practitioner during the application process and for the extent of their participation in the program. Applicants Signature:_____. Date:_____ Practitioners Signature:_____. Date:_____		