Medical Form (Medical Alert Application)

Medical Detection Dogs
Registered Charity No: 1124533

Please ask your Healthcare Professional for the medical condition you are applying for to fill in the details below.
Please then return it to us with your completed application form.

Applicant's details (applicant to complete and sign):

Name: . . . . Date of Birth: . . . .

Address:. . . . .

. . . .

. . . . .Postcode: . . . .

Please release the requested medical information regarding my condition to Medical Detection Dogs. The information will not be used for any purpose other than to evaluate my application for a Medical Alert Assistance Dog. Thank you.

Applicant's signature: . . . . .Date:. . . . .

To the Health Care Professional completing this report:

Medical Detection Dogs greatly appreciates your time and attention in completing this form. Recipients are given extensive training in handling and caring for an assistance dog. Your information is essential for an accurate evaluation of the applicant.

THIS FORM IS BEING COMPLETED BY:

Name of Consultant / Specialist Nurse / Therapist: . . . .

Telephone . . . . E-mail: . . . .

Address: . . . .

Secretary's contact details (if relevant): . . . .

. . . .

1. What medical condition is the applicant under your care for? . . . .
2. When was the applicant diagnosed with this condition?: . . . .
3. Is this applicant's care by GP only, by specialist consultant only or by both? . . . .
4. Please give details of the current treatment in terms of medication, therapy or other interventions.

. . . .

. . . .

. . . .

5. When was the applicant last seen for a review? . . . .
6. How often is the applicant followed up regarding their medical condition? . . . .

7. Has the applicant / family undergone any of the following (and when):

- Regular reviews by a specialist healthcare team . . . .
- Psychological assessment / involvement . . . .
- Conventional therapies / interventions or medications used for this medical condition (please describe)

. . . .

8. Are you aware of whether the applicant has had frequent episodes / collapses in the last 12months? If yes, please describe what these episodes would typically consist of.

Yes	No

. . . .

. . . .

9. Are you aware of whether the applicant has been hospitalised due to their medical condition (exacerbation of) in the last 12months?

Yes	No

10. Do you think this applicant is compliant with the management of their condition?

Yes	No

11. Does the applicant avoid or is unable to participate in activities? If yes please give details.

Yes	No

. . . .

. . . .

12. Any further significant medical history. Please give details:

. . . .

. . . .

. . . .

. . . .

13. Please provide a brief report as to how the medical condition impacts upon the applicant's daily life or that of his/her family? (Please use additional pages if required)

. . . .

. . . .

. . . .

. . . .

14. Are there any other treatments / interventions your team is able to offer the applicant or are they waiting to receive with regard to their medical condition management?

. . . .

. . . .

Signature . . . . .Date. . . . .

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Medical Questionnaire (applicant)

Name .... Date of Birth ....

1. Medical condition for which you are applying for an assistance dog.

....

2. How is the condition currently treated / managed?

....

....

....

3. At what age/date was the medical condition diagnosed? ....

4. Do you have any other medical conditions? If yes please give details

Yes	No

....

....

....

5. Please list your regular medications (inc. dose and frequency): ....

....

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....

6. Please describe the episodes you have in as much detail as possible, including when they tend to occur, how they affect you and for how long:

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7. Please list any medications you take or intervention action you do when an episode occurs that you would want an assistance dog to detect.

. . . .

. . . .

. . . .

. . . .

8. How often can you tell by your symptoms that you are about to experience an episode?

always	sometimes	never

9. Please describe any of the symptoms you may get or that other people may notice:

. . . .

. . . .

. . . .

. . . .

10. Do you / can you do anything to avoid these episodes? Please give details:

Yes	No

. . . .

. . . .

. . . .

11. How often in an average 3-month period have you had an episode where:

a) You treated yourself immediately? . . . .

b) You needed someone to help you? . . . .

c) You needed an ambulance or admission to hospital?. . . . .

d) No treatment was available / given? . . . .

12. Do you have limited mobility? If yes, please give details:

Yes	No

. . . .

. . . .

. . . .

13. Do you exercise regularly? If so please give details . . . .

Yes	No

. . . .

. . . .

14. Do you drink alcohol? If yes, how many units per week (1unit = 1 small glass wine/half pint/a single shot.

Yes	No

. . . .

15. Do you feel these episodes affect the quality of your life? If yes, please describe.

Yes	No

. . . .

. . . .

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17. Any further comments you would like to make regarding your medical condition? Please complete on a separate sheet if required

. . . .

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. . . .

. . . .

date completed: ……. / ……. / ……. .