Patient Authorization for Disclosure of Health Information:

Please sign the form below and ask your therapist to return this page and the **Therapist Referral Questionnaire** directly to Victory Service Dogs.

Patient Name:_____ Patient Date of Birth:_____

Person/Organization Disclosing Information:

_____
_____
_____
_____
_____

Organization Receiving Information:
Victory Service Dogs Inc.
4440 Barnes Road, Ste. 200
Colorado Springs, CO 80917
(719) 651-8559
application@victoryservicedogsinc.org

This authorization will remain effective from (today's date)_____for the period of two years or until such time as the person named above is discharged from the Victory Service Dog program.

☐ **I hereby authorize the use or disclosure of my protected health information as specified above. This authorization permits disclosure of information about mental illness or substance abuse conditions, as well as other health conditions and information.**

☐ **I understand that this authorization is voluntary and that I may refuse to sign it.**

☐ **I understand that I may revoke this authorization at any time by giving written notification to my provider or any member of the office staff. A revocation will not affect any action taken in reliance on the authorization prior to the revocation.**

☐ **I understand that, if the recipient is not a health care provider or a health plan, the information disclosed under this authorization may no longer be protected by federal privacy regulations & may be re-disclosed by the recipient.**

Information requested:
Information regarding assessment, diagnosis, all medical conditions that require use of service dog, and substance abuse history

Authorization

_____ _____
Printed name of Patient Date

_____
Signature of Patient

Therapist Referral Questionnaire

Please give questionnaire to your therapist and have them return directly to Victory Service Dogs Inc.

What is the patient's primary diagnosis?
What are the patient's primary symptoms?
What other conditions/diagnoses does the patient have?
Medications taken on a regular basis (please list):

How severe is the patient's mobility impairment?

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

How severe is the patient's cognitive impairment?

None		Often needs assistance		Needs full-time care
☐1	☐2	☐3	☐4	☐5

Do limitations affect patient's ability to control his/her own behavior?

None		Moderate		Poor self-control
☐1	☐2	☐3	☐4	☐5

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

Ineffective		Moderate		Very competent
☐1	☐2	☐3	☐4	☐5

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

Unreliable		Moderate		Very reliable
☐1	☐2	☐3	☐4	☐5

To what degree do limitations affect patient's ability to perform Activities of Daily Living (ADL)

Normal		Moderate		Totally reliant
☐1	☐2	☐3	☐4	☐5

Therapist Referral Questionnaire

Activities of Daily Living (ADL) refers to the ability to meet personal care needs, i.e. feeding, bathing, dressing, etc., as well as the ability to perform tasks necessary for independent living, i.e., be compliant with therapy and medications, manage finances, maintain home, acquire outside services.

Cognitive and Emotional Evaluation of Patient (choose all that apply):

☐Able to exercise judgement and make decisions necessary for ADL
☐Able to sustain attention span
☐Manifesting inappropriate behavior beyond his/her control
☐Able to control physical or motor movement sufficient to sustain ADL
☐Capable of perception and memory to the degree necessary to sustain ADL
☐Able to follow directions and learn to the degree necessary to sustain ADL
☐Under medication which impairs functioning
☐Capable of decisions about personal and others' needs and safety
☐Any behavioral outbursts (anger, rage, black outs)

Does patient have history of domestic violence or intimate partner violence? If so, please describe.
Does patient have a history of animal abuse? If so, please describe.
Does patient have a history of substance abuse?
Has the patient ever been in any level of substance abuse treatment? ☐Yes ☐No If yes, when, where, level of care and duration?
Any physical or mental complications due to drug and/or alcohol use? ☐Yes ☐No If yes, please describe.

Therapist Referral Questionnaire

Has patient refused treatment or referral to a substance abuse treatment center? ☐Yes ☐No
Can you recommend that this patient receive a service dog? ☐Yes ☐No In what ways do you feel your patient would benefit from a service dog?
Do you feel that the patient is capable of properly caring for a service dog? This would include the daily physical and mental needs of the dog as well as the financial commitment a service dog requires. (ASPCA estimates $1500-$2000/year for pet ownership) ☐Yes ☐No
May we contact you with questions? ☐Yes ☐No Contact information:
Additional comments or remarks:

_____

Printed Name

_____ _____

Signature Date

Mail/Email to:

Victory Service Dogs
Attention: Director of Training
4440 Barnes Road, Ste. 200
Colorado Springs, CO 80917
application@victoryservicedogsinc.org