

# Extra-Scents Diabetic Alert Dogs

Mail to:  
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## Application for Diabetic Alert Dog

NAME: (PERSON DOG IS FOR)		APPLICATION DATE:
GENDER: <input type="checkbox"/> FEMALE <input type="checkbox"/> MALE	MARITAL STATUS: <input type="checkbox"/> SINGLE <input type="checkbox"/> MARRIED <input type="checkbox"/> DIVORCED	DATE OF BIRTH:
PARENT NAME: (IF CHILD)		
ADDRESS:		
HOME PHONE:	WORK OR CELL PHONE:	
EMAIL ADDRESS:		
<input type="checkbox"/> TYPE 1 DIABETES <input type="checkbox"/> TYPE 2 DIABETES	INSULIN DEPENDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO	DATE OF DIAGNOSIS:
METHOD IF INSULIN IF INSULIN DEPENDENT: (SHOT, PUMP, ETC.)		
LIST ANY SECONDARY DISABILITIES:	CHECK ANY AFFECTS OF YOUR SECOND. DISABILITY:	
	<input type="checkbox"/> Deafness <input type="checkbox"/> Speech Impairment <input type="checkbox"/> Reduced Stamina <input type="checkbox"/> Hearing Loss <input type="checkbox"/> Coordination Problems <input type="checkbox"/> Limited Mobility <input type="checkbox"/> Memory Loss <input type="checkbox"/> Spasticity <input type="checkbox"/> Slowed Development <input type="checkbox"/> Vision Impairment <input type="checkbox"/> Muscular Weakness <input type="checkbox"/> Other: (please specify)	

HEIGHT:	WEIGHT:	SEIZURES? <input type="checkbox"/> YES <input type="checkbox"/> NO	IF "YES" WHAT TYPE?	LIST TREATMENTS/ MEDICATIONS USED FOR SEIZURES:
<p>DO YOU HAVE ANY OF THE FOLLOWING CONDITIONS? (Check all that apply)</p> <p><input type="checkbox"/> ALLERGIES    <input type="checkbox"/> CHRONIC PAIN    <input type="checkbox"/> HEIGHTENED EMOTIONS</p> <p><input type="checkbox"/> DEPRESSION    <input type="checkbox"/> SKIN SENSITIVITY    <input type="checkbox"/> HEAT/COLD SENSITIVITY</p> <p><input type="checkbox"/> BRITTLE BONES    <input type="checkbox"/> BALANCE PROBLEMS</p>				
<p>DO YOU USE ANY OF THE FOLLOWING? (Check all that apply)</p> <p><input type="checkbox"/> Prosthesis    <input type="checkbox"/> Leg Brace    <input type="checkbox"/> Electric Wheelchair    <input type="checkbox"/> Walker</p> <p><input type="checkbox"/> Manual Wheelchair    <input type="checkbox"/> Wrist Brace    <input type="checkbox"/> Hearing Aid    <input type="checkbox"/> Crutch/Cane</p> <p><input type="checkbox"/> Other: (Please specify)</p>				
<p>NAME OF PRIMARY CARE PHYSICIAN:</p> <p>PHYSICIAN PHONE:</p>				
<p>NAME(S) OF OTHER HEALTH CARE PROFESSIONALS: (particularly those who treat your diabetes)</p> <p>PHONE NUMBERS:</p>				
<p>DESCRIBE YOUR HOUSING ARRANGEMENT: (HOUSE, APARTMENT, ETC.)</p>			<p>DO YOU HAVE A YARD? IS IT FENCED?</p>	
<p>DESCRIBE YOUR NEIGHBORHOOD: (quiet, a lot of children around, rural, suburban, traffic, commercial, etc.)</p>				

PLEASE LIST ALL THOSE IN YOUR HOUSEHOLD:		
NAME:	RELATIONSHIP:	AGE:
DO YOU HAVE AN ATTENDANT?  <input type="checkbox"/> FULL-TIME <input type="checkbox"/> PART-TIME	HAVE YOU EVER HAD A DOG?  <input type="checkbox"/> YES <input type="checkbox"/> NO	
DESCRIBE YOUR EXPERIENCES WITH THE DOG(S):          		
DO OTHER ANIMALS LIVE WITH YOU (OR VISIT FREQUENTLY)?  IF SO, DESCRIBE BREED, AGE, GENDER, ETC.)          		
WHO WILL ASSIST WITH THE DAILY CARE OF YOUR SERVICE DOG?	ARE YOU (OR ANYONE IN YOUR HOUSEHOLD) ALLERGIC TO ANIMALS?	ARE YOU (OR ANYONE IN YOUR HOUSEHOLD) CONCERNED WITH FLEAS AND SHEDDING OF THE DOG?
DOES ANYONE IN THE HOUSEHOLD HAVE CONCERNS ABOUT HAVING A SERVICE DOG LIVING IN THE HOME? (please describe concerns)	DO YOU WANT THE DOG TO ASSIST YOU WHILE AT WORK/SCHOOL?	ARE THERE CONCERNS WITH YOUR EMPLOYER/SCHOOL WITH HAVING THE DOG ASSIST YOU?

WHAT ARE THE QUALITIES YOU ARE MOST LOOKING FOR IN A SERVICE DOG?  
(circle all that apply)

Serious	Playful	Slow	Dependent	Independent	Confident
Trusting	Submissive	Dependable	Assertive	Loving	Friendly
Attentive	Energetic	Sensible	Responsible	Sweet	Happy
Stable	Calm	Easy going	Devoted	Excitable	Communicative
Smart	Protective	Willing to please	Sociable	Pleasant	relaxed

WHAT IS YOUR MODE OF TRANSPORTATION? (SMALL CAR, VAN, ETC.)

ARE YOU AWARE THAT THIS DOG WILL NOT BE A CURE FOR DIABETES OR ANY OTHER DISABILITY, THAT IT WILL BE THERE ONLY TO ASSIST YOU? (EXPLAIN)

ARE YOU AVAILABLE FOR US TO COME TRAIN YOU WITH YOUR DOG FOR A 2-WEEK PERIOD?

PLEASE ATTACH TO THIS APPLICATION A SHORT AUTOBIOGRAPHY ABOUT YOURSELF. (BOTH CHILD AND PARENTS)

**THIS SECTION TO FILLED OUT BY HEALTH CARE PROVIDER:**

NAME:

PHONE NUMBER:

DESCRIBE THE EXTENT OF YOUR PATIENT'S ILLNESS:

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ARE YOU SUPPORTIVE OF YOUR PATIENT RECEIVING A SERVICE DOG? (please explain)

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