MENTAL HEALTH INFORMATION AND VERIFICATION FORM

Old Glory Service Dogs 4 Veterans, Inc. provides Service Dogs to First Responders and Veterans with service-connected PTSD, TBI, MST, and/or other mobility disabilities. Critical to our ability to pair a veteran with a Service Dog is the veteran's full participation in our training at our facility. As a team, the veteran, and Service Dog train one and a half hours at our scheduled training and train at home on their own time Our member must be able to participate and show they are capable with required tasks, interacting with other veterans and staff, learn in a open room setting, and safely handle and care for a Service Dog.

("Veteran") is applying to be a part of our Service Dog program, including attending OGSD training. So that we may evaluate the Veteran's application, please provide the mental health information and verification requested below.

1. **Is the Veteran currently in treatment for Post-Traumatic Stress Disorder (PTSD), Traumatic Brain Injury (TBI), Military Sexual Trauma (MST), and or another mental health ailment?** Yes ◉ No ○

2. **Has the Veteran been diagnosed with any psychiatric conditions?** Yes ○ No ○

If yes, which psychiatric conditions is the veteran diagnosed with?

Bipolar _____. Schizophrenia_____ Borderline Personality Disorder_____

Multiple personality Disorder _____ Other _____

Is a treatment plan in place for diagnosis? Yes ○ No ○

Please provide details regarding all relevant diagnosis(es):

_____

_____

3 **Is the Veteran currently a threat to self or others and/or suicidal?** Yes ○ No ○

Please provide details:

_____

_____

4**. Is the Veteran pursuing a Service Dog as a first level of treatment?** Yes ○ No ○

Please provide details:

_____

_____

5**. Please describe the Veteran's ability to cope with and manage anger.**

_____

_____

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6. **Please describe the Veteran's overall mental health status and treatment plan, including any substance abuse, addiction, and/or dependency other than for prescribed medications.**

7**. Do you have any concerns about the Veteran's mental and emotional ability to take part in training which may include exposure to crowds, loud and/or unexpected noises, and interactions with the public?**
Please explain:

Verifying Physician/Clinician

I hereby verify that the information I have provided above accurately and completely describes the named Veteran's mental health status and treatment as I know and/or, in my professional judgment, have reason to believe it to be.

Signature

Printed name Licensing Body License/Certification #

Date

Phone Email

Authorization for Release of Private Health Information

I _____ authorize _____
(healthcare provider) to disclose and discuss with Old Glory Service Dogs 4 Veterans, Inc. the protected health information described and requested above. This authorization shall expire upon withdrawal of my application for a Service Dog from Old Glory Service Dogs 4 Veterans, Inc. or, if my application is not withdrawn, the retirement of the last Service Dog I receive from Old Glory Service Dogs 4 Veterans Inc.

Patient or personal representative

Signature of patient or personal representative

Printed name of patient or personal representative and relationship to patient

Date

PRIMARY CARE PHYSICIAN'S REPORT FOR SERVICE DOG APPLICATION

Old Glory Service Dogs 4 Veterans, Inc. provides Service Dogs to First Responders and Veterans with service-connected PTSD, TBI, MST, and/or other mobility disabilities. Critical to our ability to pair a veteran with a Service Dog is the veteran's full participation in our training at our facility. As a team, the veteran, and Service Dog train one and a half hours at our scheduled training and train at home on their own time Our member must be able to participate and show they are capable with required tasks, interacting with other veterans and staff, learn in a open room setting, and safely handle and care for a Service Dog.

("Veteran") is applying to be a part of our Service Dog program, including attending OGSD training. So that we may evaluate the Veteran's application, please provide the mental health information and verification requested below.

SECTION 1: VETERAN IDENTIFICATION

Full Name: _____

Last First Middle Maiden

Date of Birth: _____

Month Day Year Age

Address: _____

Street Address City State Zip Code

Date of last Exam: _____

Month Day Year

Height: _____ Weight: _____

Feet Inches Pounds

How long has the Veteran been under your care? _____

Years Months

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I.OVERALL HEALTH

Please list the Veteran's current medical conditions, disabilities, disorders, illnesses, and injuries, and describe each, including any related physical limitations or restrictions.

Is the Veteran physically capable of training a Service Dog at their home safely? Please explain.

Is the Veteran physically capable of handling a medium to large size dog, weighing between 50-75lbs? Please explain.

Do you have any concerns about the Veteran's physical, mental, emotional, and/or cognitive ability to train one and a half hours at our scheduled training and train at home on their own time which may include exposure to crowds, loud and/or unexpected noises, interactions with the public, and classroom instruction? Please explain.

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II. **MENTAL HEALTH**

Has the Veteran been diagnosed with any psychiatric conditions? If so, Which:

Bipolar _____ Schizophrenia _____ Borderline Personality Disorder _____

Multiple Personality Disorder _____ Other _____

Is a diagnosis or treatment plan in place? _____

Does the Veteran have one or more of our program's qualifying disabilities, PTSD, TBI, MST, and/or other disability and if so, is the Veteran's disability service-connected?
Please note any diagnosis/certification of these disabilities.

_____

_____

_____

III. **VISION**

Is the Veteran legally Blind? Yes ◯ No ◯

If not legally blind, does the Veteran have substantial vision impairment and/or visual disturbances such as double vision? Please explain the impact on the Veteran, including how and to what degree it is correctable with contact lenses and/or glasses.

_____

_____

IV. **HEARING/SPEECH**

In each ear, how is the Veteran's hearing?

Left: Normal ◯ Abnormal ◯ Right: Normal ◯ Abnormal ◯

If abnormal, what is the degree of hearing loss in each ear _____

Does the Veteran utilize hearing aids? Yes ◯ No ◯

Does the Veteran have any speech impediments? Yes ◯ No ◯

Please explain any communication difficulties the Veteran experiences due to hearing and/or speech issues.

_____

_____

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V.**ALLERGIES**

Is the Veteran allergic to any of the following? (if yes, please provide allergy test results.)

Dogs, including allergies related to dander, urine, and/or fur: _____

Medication: _____

Food: _____

Other: _____

VI.**CARDIOPULMONARY**

Blood Pressure: _____ / _____ Pulse: _____

Which, if any, conditions does the Veteran have?

☐ Hypertension ☐ Emphysema ☐ Heart Murmur ☐ Heart Attack

☐ Asthma ☐ Lung Disease ☐ Congestive Heart Failure ☐ Stroke

☐ Angina ☐ Coronary Ailment ☐ Arteriosclerosis

Other Condition(s): _____

VII.NEUROLOGICAL

Does the Veteran have a seizure disorder and/or experience seizures? Yes ◯ No ◉

If so, how frequently does the Veteran experience a seizure? _____

What was the date of the Veteran's last seizure: Month: _____ Year: _____

Severity of last seizure: _____ Frequency of seizures: _____

Does the Veteran take anti-seizure medication? Yes ◯ No ◯

What, if anything, triggers the Veteran's seizures such that the Veteran must avoid it?

_____

To what degree does the Veteran experience issues with balance, coordination, vertigo, and/or dizziness?

_____

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Is the Veteran at risk for falls? Yes ◯ No ◯

If yes, please explain:

Please describe any cognitive difficulties which may impact the Veteran's ability to understand, learn, retain, and/or apply information, including steps for safe handling of and caring for a Service Dog.

VIII.**ORTHOPEDIC**

Does the Veteran have physical limitations related to any of the below? Yes ▢ No ▢

☐ Back ☐ Neck ☐ Shoulder (Right or Left ☐ Arm (Right or Left)

☐ Wrist (Right or Left) ☐ Leg (Right or Left) ☐ Foot (Right or Left)

Please Explain:

Does the Veteran have sufficient motion in upper extremities and hand strength to work with and handle a medium to large size (50-75 lbs.) Service Dog? Yes ◯ No ◯

Does the Veteran use a cane, walker, or wheelchair? Yes ◯ No ◉

If yes, at what frequency does the Veteran use one of these aids?

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Verifying Physician/Clinician

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Signature

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Patient or personal representative

Signature of patient or personal representative

Printed name of patient or personal representative and relationship to patient

Date

AGREEMENT TO SUPPORT

Veterans who are paired with Old Glory Service Dogs 4 Veterans, Inc. Service Dog must identify someone who agrees to provide support to the Service Dog team. This "support Person" will provide an immediate, temporary home for the Service Dog if the member becomes unwilling or unable to, as in, for example, a medical emergency. The Support Person will contact Old Glory Service Dogs 4 Veterans, Inc. as soon as he/she becomes aware of the need for support and will work with Old Glory Service Dogs 4 Veterans, Inc. to ensure that the Service Dog remains safe and cared for.

Signifying your commitment to serve as a Support Person for _____ ("Member Candidate"), please attest to the following:

1. 1. I have agreed to become a Support Person for Member Candidate.

Initials: _____

2. 2. I have the following relationship with the Member Candidate. _____

Initials: _____

3. I am aware that the Member Candidate has applied to receive a Service Dog from Old Glory Service Dogs 4 Veterans, Inc. and support the placement of a Service Dog with the Member Candidate.

Initials: _____

4. I will immediately provide a temporary home and care for the Service Dog if the Member becomes unwilling or unable to, as in, for example, a medical emergency.

Initials: _____

5. I will contact Old Glory Service Dogs 4 Veterans, Inc. as soon as he/she becomes aware of the need for support and will work with Old Glory Service Dogs 4 Veterans, Inc. to ensure that the Service Dog remains safe and cared for.

Initials: _____

Signature of Support Person: _____

Printed Name of Support Person: _____

Date: _____

Phone: _____

Email: _____

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