Mental Health Report

I, _____, (Patient / print name) give my permission for the below named physician to release the information requested in this form.

Patient's Signature:_____ Date:_____

Print name:_____

Phone:_____

Date Signed: _____

Balance of Form To Be Completed by Physician

Is the person named above your patient/client? ___Yes ___No
Does the patient/client have a diagnosed mental illness? ___Yes ___No
If yes, what is the diagnosis? _____
_____
_____

When was your diagnosis made? _____

Activities of Daily Living (ADL):
Is the patient/client able to exercise judgement and make decisions necessary for ADL? ___Yes ___No
Is the patient/client capable of perception and memory to the degree necessary to sustain ADL? __Yes ___No
Is the patient/client able to follow directions and learn to the degree necessary to sustain ADL? __Yes __No
Is the patient/client capable of decisions about personal and other's (people and pets) needs and safety? ___Yes __No

Here is a brief overview of our program:

- It takes an average of 6 to 12 months to complete the program.
- Client must attend a minimum of 4 lessons every month
- There will be a minimum of 2 lessons in the client's home.
- Client must practice what he/she learns in regular daily training sessions with the dog.
- Client must make an on-going commitment to maintain the dog's training after completion of the program.
- Client must ensure that the dog is healthy and well groomed.

Arizona Greyhound Rescue, Heartfelt Hound Program
8987 E Tanque Verde Rd., PMB 309/153
Tucson, AZ. 85749
520.886.7411
president@azgreyhoundrescue.org
www.azgreyhoundrescue.org
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In your opinion, is the client capable of managing these program requirements? ___Yes __No
If no, please explain_____
_____
_____
_____

In your opinion, is the client capable of properly caring for a dog? This includes remembering and providing for its physical needs(feeding, watering, toilet and exercising several times a day); having transportation to classes and veterinary visits; and the apparent financial means for providing food, equipment, annual veterinary care, emergency care (if necessary), and training classes? ___Yes ___No

If no, please explain: _____
_____
_____
_____
_____

Any other information regarding this client that you would like to share that is pertinent? _____
_____
_____
_____
_____
_____

Physician's Signature: _____

Print Name:_____

Physician's Address:_____

City, State Zip:_____

Physician's Phone: _____

Email:_____

Date Signed:_____

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