Assistive K9s

DISABILITY CONFIRMATION

PRACTITIONER DETAILS	PATIENT DETAILS
Name:	Name:
Clinic:	Date of Birth:
Role:	

In your professional opinion, does your patient, named above, meet the following criteria of having a disability as defined by the Disability Discrimination Act (1992)

Disability, in relation to a person, means:

(a) total or partial loss of the person's bodily or mental functions; or

(b) total or partial loss of a part of the body; or

(c) the presence in the body of organisms causing disease or illness; or

(d) the presence in the body of organisms capable of causing disease or illness; or

(e) the malfunction, malformation or disfigurement of a part of the person's body; or

(f) a disorder or malfunction that results in the person learning differently from a person without the disorder or malfunction; or

(g) a disorder, illness or disease that affects a person's thought processes, perception of reality, emotions or judgment or that results in disturbed behaviour; and

(h) includes a disability that:

- presently exists; or
- previously existed but no longer exists; or may exist in the future; or
- is imputed to a person.

Does your patient's disability significantly impact their ability to perform the activities of daily living, including social and community participation? **Yes** ☐ **No** ☐

Do you and your patient believe that a dog could be trained to help your patient to perform the activities of daily living, including social and community participation? **Yes** ☐ **No** ☐

Does your patient have the ability to care for, and provide a safe environment for, a dog, and/or do they have the needed support to achieve this? **Yes** ☐ **No** ☐

Signature: Date: