



the good dog foundation
 dogs helping humans heal

**THE GOOD DOG FOUNDATION
 VETERINARY MEDICAL EVALUATION**

Good Dog requires an annual veterinary exam reported on this Good Dog veterinary form for every certified Good Dog. An updated veterinary report must be turned in within 12 months from the date of the last veterinary report. Please call the Good Dog office at (888) 859-9992 if your veterinarian has any questions about completing this report.

Owner's Name: _____

Mailing address: _____

Phone: Home: _____ Cell: _____

Fax: _____ E-mail: _____

Pet's name: _____ Breed: _____

Date of birth: _____ Male _____ Female _____ Spayed/Neutered _____

Weight: _____ Coat color: _____

Veterinary Clinic: _____

Mailing address: _____

Phone: _____ Fax: _____

Attending veterinarian: _____

The Good Dog Foundation complies with state laws regarding vaccinations. We understand that this animal's veterinarian is in the best position to prescribe other vaccinations or titers that will ensure the animal's immunity and safety in a health care facility and will ensure client health and safety.

Vaccination:	Expiration Date
Rabies (State Law):	_____
Other (Please list):	_____
_____	_____
_____	_____
_____	_____

The Good Dog Foundation requires an annual stool sample even for dogs on heartworm and tick prevention.

Date of most recent stool sample (must be within the last six months) _____ Result _____

Is the dog on heartworm preventative? _____

Is the dog on an appropriate tick prevention regime? _____

Are you or the owner aware of any current medical problems?

Recently noticed: Diarrhea ___ Scratching ___ Vomiting ___
Frequent urination ___ Coughing ___ Sneezing ___ Open sores ___
Runny eyes ___ Runny nose ___ External parasites ___ Anorexia ___ Lethargy ___

Please examine the following: (make any comments you deem necessary)

N	Abn	Comments
___	___	General condition/cleanliness _____
___	___	Nails _____
___	___	Coat _____
___	___	Integument _____
___	___	Ears _____
___	___	Eyes _____
___	___	Nose _____
___	___	Oral cavity _____
___	___	Lymph nodes _____
___	___	Urogenital _____
___	___	Auscultation _____
___	___	Abdominal Palpation _____
___	___	Temperature _____

Additional comments:

Do you feel that this dog should participate in Therapy Dog Services in healthcare facilities (keeping in mind the health of the dog, hospital patients and staff)?

Yes _____ No _____

Yes, with the following concerns addressed:

Veterinarian's name (Please print): _____

Veterinarian's signature: _____ **Date:** _____

Please fax this report, to the Good Dog office at (888) 861-7312 and keep a copy of this report for your records. If you cannot fax this form, please mail it to: The Good Dog Foundation, PO Box 1484, New York, NY 10276. Please do not fax and mail this form.