CURAÇAO DOLPHIN THERAPY & RESEARCH CENTER N.V.
("CDTC")
At the Curaçao Sea Aquarium Park

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Dear Sir/Madam,

You were contacted by your patient, parent or the guardian/representative of one of your patients with the request to complete the form below concerning their application for dolphin assisted therapy at the Curaçao Dolphin Therapy Center (CDTC).
The CDTC is a therapy center that offers people with a mental and/or physical disability a therapy program consisting of 10 two-hour sessions, divided over two weeks. The therapy is given by qualified therapists from different fields like physical/occupational therapy, speech pathology, behavioral therapy, special education and psychology. They are working in a multidisciplinary therapeutic team and have a treatment evaluation meeting twice a week. Furthermore, the therapists have been certified by Dolphin Aid as dolphin assisted therapy therapists or are being trained for this. All therapists are working according to behavior therapy principles. The interaction with the dolphins is used as a motivation and reward for the execution of exercises done by the patient.
Should you be interested to read about research done by Dr. Nicole Lämmermann, which states that dolphin assisted therapy works, we kindly ask you to click on the following link:
http://edoc.ub.uni-muenchen.de/15351/

The CDTC does not provide any medical treatments. In case medical care is required during the stay on Curaçao, we will refer you to the local physicians, specialists and hospitals.

In order to be able to make an adequate assessment whether the dolphin assisted therapy is sensible and useful for the participant concerned, we need information from you, information from the participant or the parents, guardian/representative and copies of relevant correspondence about the participant. We therefor ask you to completely fill out this form. Should you want to consult or should you be interested in further information about dolphin assisted therapy, you are welcome to contact us by phone (+5999 461 9886) or e-mail info@cdtc.info.

More information about our program can be found at www.cdtc.info.

Thank you in advance and collegial greetings,

The CDTC Team

APPLICATION FORM PART 2

To be filled out by the main physician

Name of physician:

Specialization:

Zip code:

Name of the hospital/practice:

Country:

Street:

Fax:

City:

Phone:

E-mail:

Name of the participant:

Date of birth of the participant:

Gender:

Please mention the diagnosis always together with the ICD-10 code

Main diagnosis:

ICD-10 Code:

Secondary diagnosis:

ICD-10 Code:

DOES ANY OF THE FOLLOWING APPLY TO THE PATIENT:

- ☐ Colostomy
- ☐ Enteral tube
- ☐ Gastrostomy
- ☐ Ileostomy
- ☐ Nasogastric (NG) tube
- ☐ Tracheostomy
- ☐ Aspiration or suctioning
- ☐ Hypersensitivity to sunlight
- ☐ Massive psychiatric disorders
- ☐ Epilepsy. If yes, how many seizures per day/week/month and how long?

- ☐ Dermatitis
- ☐ Eczema
- ☐ Fungal infections
- ☐ Rashes
- ☐ Scabies
- ☐ Fear of water

- ☐ Coma/awake coma
- ☐ Sensitivity for Otitis
- ☐ Shunts
- ☐ Tubes in ears
- ☐ Other allergies
- ☐ Other skin problems

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FURTHER REMARKS

What kind of medication does the participant receive? (ingredient, dose, brand name, effect, side-effects)

Are there any known reactions to the medications in terms of over-sensitivity or paradoxical reaction? If yes, which ones?

According to you, are there any reasons for this participant not to participate at all in water based activities? If yes, which reasons?

According to you, which possible risks can aqua based therapy evoke for the participant?

Which possible precautions would you advise for the therapeutic intervention in the water?

According to you, are there any reasons not to allow travel by airplane for this participant? If yes, what are the reasons?

According to you, are there any reasons to discourage this participant to be in the sea (together with a therapist and a dolphin)? If yes, what reasons?

Do you have any other remarks or additional information which are important concerning the stay of the participant on Curaçao?

The undersigned states that by signing this form, undersigned confirms to have read and is fully aware of the contents of this Medical, Treatment and Safety form and in responsibility to the participant is agreeing on request of the participant/parents/guardians/representatives of _____(name participant) for dolphin assisted therapy at CDTC.

Thank you for your cooperation!

Name of physician: _____

Date: _____

Signature: