



CURAÇAO DOLPHIN THERAPY & RESEARCH CENTER N.V.
("CDTC")

At the Curaçao Sea Aquarium Park

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Dear Colleague,

You were contacted by the parents/ guardian/ representatives of one of your patients with the request to complete the form below concerning their application for Dolphin Assisted Therapy at the Curacao Dolphin Therapy Center (CDTC).

The CDTC is a therapy center that offers children 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 multi disciplinary 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.

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 patient concerned, we need information from you, information from the parents and copies of relevant correspondence about the patient. We therefore 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 email (info@curacaodolphintherapy.com).

More information about our program can be found on www.curacaodolphintherapy.com

Thank you in advance and collegial greetings,

The CDTC Team



APPLICATION FORM – PART II
To be filled out by the main physician

Physician Name:

Specialization:

Address:

Hospital Name / Practice:

Postal Code:

City:

Country:

Phone:

Fax:

Email:

Name of the child:

Birth date of the child:

Gender: M/F

Diagnoses and relevant medical information:

Does any of the following apply to the child:

- | | | |
|---|---|--|
| <input type="checkbox"/> Colostomy | <input type="checkbox"/> Dermatitis | <input type="checkbox"/> Coma/ Awake coma |
| <input type="checkbox"/> Colostomy | <input type="checkbox"/> Eczema | <input type="checkbox"/> Sensitivity for Otitis |
| <input type="checkbox"/> Gastrostomy | <input type="checkbox"/> Hypersensitivity to sunlight | <input type="checkbox"/> Shunts |
| <input type="checkbox"/> Ileostomy | <input type="checkbox"/> Fungal infections | <input type="checkbox"/> Tubes in ears |
| <input type="checkbox"/> Nasogastric (NG) tube | <input type="checkbox"/> Rashes | <input type="checkbox"/> Water fear |
| <input type="checkbox"/> Tracheostomie | <input type="checkbox"/> Scabies | <input type="checkbox"/> Massive psychiatric disorders |
| <input type="checkbox"/> Aspiration or suctioning | <input type="checkbox"/> Other skin problems | <input type="checkbox"/> Epilepsy. If yes: how many seizures per day/ week/ month/ how long? |
| | <input type="checkbox"/> Other Allergies | |



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

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

According to you are there any reasons for this child 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 child concerned?

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 child? If yes, what are the reasons?

According to you are there any reasons to discourage this child 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 child 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 child is agreeing on the request of the parents/ guardians/ representatives offor Dolphin Assisted Therapy at the CDTC.

Thank you for your cooperation!

Date:

Name physician:

Signature:

Stamp: