The Equestrian Therapy Program

Date: ______________
Dear Physician:

Your patient _____________________ is interested in participating or continuing therapeutic riding. In order to safely provide this service, The Equestrian Therapy Program requests that you complete/update the attached Physicians Referral form and Medical History. Please note that the following conditions may suggest precautions or contraindications to therapeutic riding. Therefore, when completing this form, please note whether these conditions are present and to what degree.

Orthopedic	**Yes**	**Degree**	**Neurological**	**Yes**	**Degree**
Spinal Fusion			Hydrocephalus/shunt		
Spinal Instabilities/Abnormalities			Spina Bifida		
Atlantoaxial Instabilities			Tethered Cord		
Scoliosis			Chiari II Malformation		
Kyphosis			Hydromyelia		
Lordosis			Paralysis due to Spinal Cord Injury		
Hip Subluxation & Dislocation			Seizure Disorders		
Osteoporosis					
Pathologic Fractures			**Medical/Surgical**		
Coxas Arthrosis			Allergies		
Heterotopic Ossification			Cancer		
Osteogenesis Imperfecta			Poor Endurance		
Cranial Deficits			Recent Surgery		
Spinal Orthoses			Serious Heart Condition		
Internal Spinal Stabilization Devices			Stroke (Cerebrovascular Accident)		
			Peripheral Vascular Disease		
Secondary Concerns			Varicose Veins		
Behavior Problems			Hemophilia		
Acute exacerbation of chronic disorder			Hypertension		
Indwelling catheter			Diabetes		

Thank you very much for your assistance. If you have any questions or concerns regarding this patient's participation in therapeutic riding, please feel free to contact The Equestrian Therapy Program at the address/telephone number indicated below.

Physician Signature: ____

Sincerely,

The Equestrian Therapy Program Staff

22532 Bowsher Road • Cridersville, Ohio 45806 • Phone (419) 657-2700 • Fax (419) 657-2887

The Equestrian Therapy Program

Physician's Referral Form

Note: All Blanks on this entire form must be filled out and signed by the Physician!

Name: ____Name of Parent/Guardian: _________________________

Address: _______________________________________ City: ______________________ State: ______ Zip: __________

Diagnosis: ____On Set: _____________

****Mandatory for persons with Down Syndrome:**
Cervical X-Ray for Atlantoaxial Instability: Positive: _______ Negative: _______ X-Ray Date: ____________

Tetanus Shot: Yes No Date: _______________ Height: ______________ Weight: _____________________

Seizure Type: ________________________ Controlled: _______________ Date of last Seizure: _________________

Medications: ____

Health History
Please indicate if the patient has a problem and/or surgeries in any of the following areas by checking yes or no. If yes, please comment.

Areas	Yes	No	Comments
Hearing			
Vision			
Communication			
Balance			
Coordination			
Spasticity/Rigidity			
Muscular			
Neurological			
Orthopedic (Bone/Joint)			
Heart/Circulation			
Sensation			
Pain			
Incontinence			
Allergies			
Thinking/Cognition			
Emotional/Mental Health			
Behavioral			
Other			

Mobility: **Independent Ambulation**: Yes No **Crutches**: Yes No **Braces**: Yes No **Wheelchair**: Yes No

Please indicate any special precautions/contraindications: ____

____

Given the above diagnosis and medical information, this person is not medically precluded from participation in equine assisted activities. I understand that The Equestrian Therapy Program will weigh the medical information given against the existing precautions and contraindications. Therefore, I refer this person to The Equestrian Therapy Program for ongoing evaluation to determine eligibility for participation.

Physician's Name (please print): ____

Physician's Signature: ____ Date: ______________

Address: ____________________________________ City: ______________________State: ______ Zip: __________

Phone: ______________________ Fax: _____________________ email: ____________________________________

Please give as much pertinent information as possible on reverse side.