



# The Equestrian Therapy Program 1 of 3

## Physician's Referral Form

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 Physician's 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.

| <b>Orthopedic</b>                      | <b>Yes</b> | <b>Degree</b> | <b>Neurological</b>                 | <b>Yes</b> | <b>Degree</b> |
|--|------------|---------------|-------------------------------------|------------|---------------|
| 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                           |            |               | AAI or Focal Neurological Disorder  |            |               |
| Pathologic Fractures                   |            |               |                                     |            |               |
| Coxas Arthrosis                        |            |               | <b>Medical/Surgical</b>             |            |               |
| Heterotopic Ossification               |            |               | Allergies                           |            |               |
| Osteogenesis Imperfecta                |            |               | Cancer                              |            |               |
| Cranial Deficits                       |            |               | Poor Endurance                      |            |               |
| Spinal Orthoses                        |            |               | Recent Surgery                      |            |               |
| Internal Spinal Stabilization Devices  |            |               | Serious Heart Condition             |            |               |
|  |            |               | Stroke (Cerebrovascular Accident)   |            |               |
| <b>Secondary Concerns</b>              |            |               | Peripheral Vascular Disease         |            |               |
| Behavior Problems                      |            |               | Varicose Veins                      |            |               |
| Acute exacerbation of chronic disorder |            |               | Hemophilia                          |            |               |
| Indwelling catheter                    |            |               | Hypertension                        |            |               |
|  |            |               | Diabetes                            |            |               |

**Patient's with Down Syndrome must have additional information provided (see back of page 2 following Ambulation Information).**

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.

Sincerely,  
The Equestrian Therapy Program Staff

Physician Signature: \_\_\_\_\_



# The Equestrian Therapy Program 2 of 3

## Physician's Referral Form

Name: \_\_\_\_\_ Name of Parent/Guardian: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Diagnosis: \_\_\_\_\_ On Set: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Height: \_\_\_\_\_ Weight: \_\_\_\_\_ Tetanus Shot: Yes NO Date: \_\_\_\_\_

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                   |     |    |          |

Given the patient's 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: \_\_\_\_\_

Date: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_ Email: \_\_\_\_\_

**\*\*Down Syndrome patients need additional information completed on reverse of this page.**



# The Equestrian Therapy Program 3 of 3

## Physician's Referral Form

**Patient's name:** \_\_\_\_\_

**Mobility Information:**

|                        |     |    |
|------------------------|-----|----|
| Independent Ambulation | Yes | No |
| Crutches               | Yes | No |
| Braces                 | Yes | No |
| Wheelchair             | Yes | No |

**\*\*Mandatory for persons with Down Syndrome:**

*Persons with symptoms of AAI are not appropriate for therapeutic riding activities. It is a requirement for therapeutic riding that all individuals with Downs Syndrome be examined yearly for AAI.*

**To be completed by Physician:**

Does this patient present symptoms consistent with Atlantoaxial Instability or Focal Neurological Disorder?

YES

NO

This patient does not show signs or symptoms of Atlantoaxial Instability or Focal Neurological Disorder.

Date of examination: \_\_\_\_\_

Physician Signature: \_\_\_\_\_