RideAbility Therapeutic Riding Center Inc.
Equine Assisted Services

Dear Healthcare Provider/Physician;

Your patient: _____
is interested in being referred for Therapeutic Riding for rehabilitation.

In order to provide this service, our program requests that you complete and update the attached Medical History, Prescription for therapy, and Physician's Statement form. Please note that some of the following conditions may suggest precautions, special program design or contraindications to Therapeutic Riding. Therefore, when completing this form, please note whether these conditions are present and to what degree. Thank you.

Participant's Medical History & Physician's Statement

Participant Name: _____ D.O.B.: _____
Height: _____ Weight: _____lbs.
Address: _____
City: _____ State: _____ Zip: _____
Phone: (home)_____ (alt.) _____
Parent/Guardian that will accompany the patient: _____
Therapeutic Diagnosis: _____
Date of Onset: _____
Past/Prospective: _____
_____
Medication List: (Attach list if long)
_____
_____
_____
Allergies (medication & environmental):
_____
_____
Previous Surgeries: _____
_____
Mobility: Independent ambulation Y / N Assisted ambulation Y / N
Wheelchair Y / N Confined to Wheelchair Y / N
Braces or assistive devices used: _____

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If Down's syndrome, date of last AtlantoDens Xray _____ Result + / -
Is this Patient cleared for therapy is AtlantoDens Xray is cleared? ____ Yes ____ No
Is there a tracheostomy present? ___ Yes ___ No Why Placed? _____
When Placed? _____

Areas of current or past difficulty in the following areas	YES	NO	Comments about this problem
Auditory			
Indwelling Catheters			
Visual			
Tactile Sensation			
Speech			
Hyposensory			
Hypersensory			
Cognitive			
Weight Disorder			
Substance Abuse			
Emotional/Psychological: Animal abuse, Depression, Anger, Anxiety,Antisocial, Bipolar, Schizophrenic, Physical/sexual/emotional abuse, Danger to self or others, Fire Settings, Thought Control Disorders, etc.			
Pain			
Cardiac			
Circulatory: Hypertension, Peripheral Vascular Disease, etc.			
Integumentary (skin): rashes, photosensitivity, skin breakdown, etc.			
Immunity			
Previous infections (esp. MRSA)			
Pulmonary: Asthma, Bronchitis, Respiratory Compromise, Sleep Apnea (Central/Obstructive), Tracheostomy, Ventilatory needs			
Hematologic: Bleeding disorders			
Headaches/Migraines			
Neurologic: Hydrocephalus/Shunt, Seizures (type and frequency), Autism, ADHD,Spina Bifida/Chari II Malformations/Tethered Cord, Hydromelia, Alzheimer's,			

Multiple Sclerosis, Parkinson's, etc.			
Muscular: Muscular Dystrophy, paralysis, etc.			
Poor endurance			
Balance			
Orthopedic: Coxa Arthosis, Heterotopic Ossification, Joint sublux./dislocation, Osteoporosis, Pathologic Fractures, Spinal fusions or fixation, Spinal instability, Amputee, etc.			
Learning Disabilities			
Head trauma			
Cranial Deficits			
Syndromes: Down's Syndrome, Turner's Fragile X, Chromosome Abnormalities, etc.			
Seizure (type)			Date of last Seizure:
Cancer Patient			
Other Diagnosis			

** Have your Health Care Provider give the patient clearance for this therapy (See Below)**

MEDICAL CLEARANCE: To my knowledge there is no medical reason why this patient, _____ cannot participate is supervised, well designed equestrian activities at RideAbility Therapeutic Riding Center Inc.. However, I understand that the RideAbility Therapeutic Riding Center, Inc. will evaluate this child first and weigh the medical information above against the existing precautions and contraindications. Functional Levels and recommended individual riding programs will be designed and implemented. This Authorization does not constitute any medical guarantee nor assurance that the patient named above will achieve desired physical or psychological benefits from the program conducted by RideAbility Therapeutic Riding Center , Inc. Each patient's progress and benefits will vary.

Therapeutic Diagnosis is: _____ Date: _____

Physician/Healthcare Provider Signature: _____ MD DO NP PA

Other:

Print name_____

Address: _____

Phone: _____ License/UPIN Number: _____