

**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: _____

**** 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.