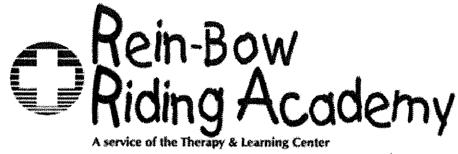

Dear Health Care Provider:

Your patient ____

is interested in participating in supervised equine activities. This may include hippotherapy and/or therapeutic riding.

In order to safely provide this service, our center requests that you complete the attached Medical History and Physician's Statement Form. Please note that the following conditions may suggest precautions and contraindications to equine activities. Therefore, when completing the form, please note whether these conditions are present, and to what degree.

Orthopedic

Atlantoaxial Instability – include neurologic symptoms

Coxarthrosis

Cranial Defects

Heterotopic Ossification/Myositis Ossificans

Joint Subluxation/Dislocation

Osteoporosis

Pathologic Fractures

Spinal Joint Fusion/Fixation

Spinal Joint Instability/Abnormalities

Neurologic

Chiari II Malformation

Hydrocephalus/Shunt

Hydromyelia

Seizure

Spina Bifida

Tethered Cord

Medical/Psychological

Allergies

Cardiac Conditions

Blood Pressure Control

Exacerbations of Medical Conditions

Hemophilia

Medical Instability

Migraines

Peripheral Vascular Disease

Respiratory Compromise

Recent Surgeries

Other

Indwelling Catheters/Medical Equipment

Poor Endurance

Skin Breakdown

Thank you very much for your assistance. If you have any questions regarding this patient's participation in equine-assisted activities, please feel free to contact the center at the address/phone indicated below. The attached form can be mailed or faxed to the address below as well.

Therapy & Learning Center
10 Garland Dr.
Jackson, TN 38305
Phone: (731) 664-3672
Fax: (731) 660-6145

Rein-Bow Riding Academy
Medical History & Physician's Statement

Participant:______________________ DOB:__________ Height:________ Weight:______

Address:____

Diagnosis:______________________________ Onset Date:______________

Past/Prospective Surgeries:______________________________________

Medications:____

Seizure Type:____________________ Controlled: Y N Date of Last Seizure:__________

Shunt Present: Y N Date of last revision:______________________________

Special Precations/Needs:______________________________________

Mobility: Independent Ambulation: Y N Assisted Ambulation: Y N Wheelchair: Y N

Braces/Assistive Devices:______________________________________

For those with Down Syndrome: Must have Atlantoaxial Instability X-ray after age 3 but within 5 yrs of starting equine-assisted program, and then annual physical exam with special reference to neurological function.

AtlantoDens Interval X-rays, date:____________ Result: + --

Neurological Symptoms of Atlanto Axial Instability:______________________________

Please indicate current or past special needs in the following systems/areas, including surgeries:

	Y	N	Comments
Allergies			
Auditory			
Visual			
Tactile Sensation			
Speech			
Cardiac			
Circulatory			
Integumentary/Skin			
Immunity			
Pulmonary			
Neurologic			
Muscular			
Balance			
Orthopedic			
Learning Disability			
Cognitive			
Emotional/Psychological			
Pain			
Other			

Given the above diagnosis and medical information, this person is not medically precluded from participation in equine-assisted activities and/or therapies. I understand that the agency will weigh the medical information given against the existing precautions and contraindications. Therefore, I refer this person to the Therapy & Learning Center for ongoing evaluation to determine eligibility and participation.

Name/Title:______________________________ MD DO NP PA Other:__________

Signature:______________________________ Date:______________

Address:____

Phone: (____)______________________________

Please return to: Therapy & Learning Center, 10 Garland Dr., Jackson, TN 38305
Fax: (731) 660-6145