



Hilltop

Therapeutic Riding Program, Inc.

Date: _____

Dear Physician:

Your patient, _____ (participant's name) is interested in participating in supervised equestrian activities.

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

Orthopedic

Atlantoaxial Instability – include neurological symptoms
Coxa Arthrosis
Cranial Deficits
Heterotopic Ossification/Myositis Ossificans
Joint subluxation/dislocation
Osteoporosis
Pathologic Fractures
Spinal Fusion/Fixation
Spinal Instability/Abnormalities

Neurologic

Hydrocephalus/Shunt
Seizure
Spina Bifida/Chiari II malformation/Tethered Cord/
Hydromyelia

Other

Age – usually under 4 years
Indwelling Catheters
Medications, i.e., photosensitivity
Poor Endurance
Skin Breakdown

Medical/Psychological

Allergies
Animal Abuse
Physical/Sexual/Emotional Abuse
Blood Pressure Control
Dangerous to self or others
Exacerbations of medical conditions
Fire Settings
Heart Conditions
Hemophilia
Medical Instability
Migraines
PVD
Respiratory Compromise
Recent Surgeries
Substance Abuse
Thought Control Disorders
Weight Control Disorder

Thank you very much for your assistance. If you have any questions or concerns regarding this patient's participation in therapeutic equine activities, please feel free to contact the center at the address/phone indicated below.

Sincerely,

Brian L. Fitzsimmons, Ph.D.
President

PARTICIPANT'S MEDICAL HISTORY & PHYSICIAN'S STATEMENT

Participant: _____ DOB: _____ Height: _____ Weight: _____
 Address: _____
 Diagnosis: _____ Date of Onset: _____
 Past/Prospective Surgeries: _____
 Medications: _____
 Seizure Type: _____ Controlled? Y ___ N ___ Date of last seizure: _____
 Shunt Present? Y ___ N ___ Date of last revision: _____
 Special Precautions, Diets/Needs: _____
 _____ May participate in all activities _____ May participate except for: _____
 Mobility: Independent Ambulation? Y ___ N ___ Assisted Ambulation? Y ___ N ___ Wheelchair? Y ___ N ___
 Braces/Assistive Devices: _____
***For those with Down Syndrome: AtlantoDens Interval X-rays, date: _____ Result: + -**
 Neurologic Symptoms of Atlanto Axial Instability: _____

This participant is up-to-date on all the following routine childhood immunization:

	Yes	No	Date:
Measles			
Rubella			
Tetanus			
Pertussis			
Polio			
Diphtheria			
Other:			

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

	Yes	No	Comments
Auditory			
Visual			
Tactile Sensation			
Speech			
Cardiac			
Circulatory			
Integumentary/Skin			
Immunity			
Pulmonary			
Neurologic			
Muscular			
Balance			
Orthopedic			
Allergies			
Learning Disability			
Cognitive			
Emotional/Psychological			
Pain			
Other			

IMPORTANT NOTE TO DOCTOR/MEDICAL FACILITY:

If you prefer to provide the requested information on your own medical form, we will accept that only when the below release section is completed, signed and dated and your form is stapled to our form.

To my knowledge, there is no reason why this person cannot participate in supervised equestrian activities. However, I understand that the therapeutic riding center will weigh the medical information above against the existing precautions and contraindications. I concur with a referral of the patient to a licensed/credentialed health professional (e.g., PT, OT, Speech, Psychologist, etc.) in the implementation of an effective equestrian program.

Name/Title: _____ M.D. D.O. Other: _____
 Signature: _____ Date: _____
 Address: _____
 Phone: _____ License/UPIN Number: _____