Positive PT LLC
P: 201-317-7243
F: 888-910-5086
Positive-PT.com

Physician's Medical Release for Hippotherapy

By providing this form to the participant's physician, I provide my consent for their disclosure of the information about the named participant required in this form to Positive PT LLC.

Participant's Information

Participant's name: _____ Today's Date: _____

Address: _____

DOB: _____ Gender: M ____ F ____

Height: _____ **Weight**: _____ ***Physician's initials are required here*** _____

It is crucial that this information be truthful and accurate. Providing inaccurate information may jeopardize the safety of the participant and others.

Medical Summary

Primary diagnosis: _____ Cause if known: _____

Other diagnoses: _____

If Down Syndrome/AAI- result of yearly neurological exam/test for AAI: ❑Negative ❑Positive

Results/date of exam/test: _____

Recent surgical procedures or hospitalization: _____

Brief current medical condition: _____

Date of last tetanus: _____

Current Medications

Name: _____ Dose: _____ For treatment of: _____

Name: _____ Dose: _____ For treatment of: _____

Name: _____ Dose: _____ For treatment of: _____

Cognitive Skills (*please rate the following skills using the scale provided*):

(0) *Not able to perform skill at this time* (1) *Beginning Skill requires moderate assistance from others* (2) *Moderate Ability requires minimal assistance from others* (3) *Mastered performs independently*

_____ Alertness/Attention _____

_____ Ability to follow 1-step commands _____

_____ Ability to follow multiple-step commands _____

_____ Activity level / endurance _____

_____ Visual ability _____

_____ Expressive Language _____

_____ Language Comprehension _____

_____ Socialization skills _____

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Abilities

Assistive Aids (*please check all that currently apply to the client, or note history in space provided*):

_____ Orthotics/Splints/Prosthetics (*specify type*): _____
_____ Cervical collar/Abdominal binder/Other trunk supports (*specify type*): _____
_____ Wheelchair/Walker/Crutches (*specify type*):_____
_____ Other assistive aids: _____

Physical Skills (*please rate the following skills using the scale provided*):

(0) *Not able to perform skill that at this time* (1) *Beginning Skill requires moderate assistance* (2) *Moderate Ability requires minimal assistance* (3) *Mastered performs independently*

_____ Head and neck control _____
_____ Unsupported sitting balance _____
_____ Unsupported standing balance _____
_____ Unsupported walking _____
_____ Upper extremity (arm) strength / movement _____
_____ Lower extremity (leg) strength / movement _____
_____ Fine motor (hand/finger) strength / movement _____
_____ Gross motor (whole body) coordination _____

Precautions/Contraindications (*Please check all that currently apply to your patient and degree of involvement, or note history in space provided. Please note that the following conditions may be a contraindication to participation*):

____ Allergies (*specify type*)_____
____ Arthritis (*rheumatoid or osteo*) _____
____ Asthma _____
____ Atlanto-Axial Instability- positive X-ray or positive neurological exam_____
____ Behaviors _____
____ Blood clots, deep vein thrombosis, peripheral vascular disease _____
____ Body temperature regulation problems _____
____ Bone abnormalities (*osteoporosis, pathologic fractures*) _____
____ Brain injury _____
____ Communicable Diseases _____
____ Contractures/limited ROM (*location*) _____
____ Gastro-intestinal or naso-gastric, or tracheal tube _____
____ Heart condition/abnormality _____
____ Hypertension _____
____ Joint/tendon laxity, subluxation, dislocation _____
____ In-dwelling catheter _____
____ Shunt _____
____ Psychiatric condition (*type*) _____
____ Respiratory complications (*type*) _____
____ Seizures (*list type, frequency and duration*) _____
Date of last seizure: _____
____ Skin integrity issues, skin breakdown, skin/decubitus ulcers _____
____ Chiari II malformation, tethered cord (*include release date*) _____
____ Scoliosis _____*Location and degree of curve*_____
____ Spinal fusion or internal fixators (*specify area, type, vertebrae involved*): _____
____ Other (*please specify*) _____

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Physician's Statement: Given the above diagnosis and medial information, this person is not medically precluded from participation in hippotherapy during physical therapy sessions. I understand that Positive PT LLC will weigh the medical information against precautions and contraindications. Therefore, I refer this person to Positive PT LLC for ongoing evaluation to determine eligibility for participation.

Patient's name: _____

Physician's name: _____

Address: _____

Phone number: _____

Physician's signature: _____

Date: _____