HART Equine Therapy Center, Inc.

10198 Brookside Road
Auburndale, WI 54412
715-305-5166   www.hartetc.com

PHYSICIAN'S REFERRAL FORM

Please complete this form in its entirety and return by mail to HART

HART Equine Therapy Center, Inc. is a therapeutic riding program designed to benefit the riders physically, socially, and emotionally. Safety equipment and specially trained horses and volunteers are used. In order to assure the fullest protection and personal benefit from the program, each rider is required to furnish the following medical information before being accepted as a riding student.

Participant's name____DOB:________________

Parent/Guardian name____

Address ____

City/State/Zip ____

Phone______________________________ CURRENT HEIGHT ______   CURRENT WEIGHT ______

200-LB WEIGHT LIMIT DEPENDANT UPON
Ambulatory Status, Range of Motion, AND Instructor Discretion

NOTE: BECAUSE OF THE NATURE OF THE ACTIVITY OF HORSEBACK RIDING, NO INDIVIDUAL DIAGNOSED WITH DOWN SYNDROME CAN BE ACCEPTED FOR RIDING INSTRUCTION WITHOUT AN ANNUAL MEDICAL CLEARANCE FROM A LICENSED PHYSICIAN THAT INCLUDES A NEUROLOGIC EXAM THAT SPECIFICALLY DENIES ANY SYMPTOMS CONSISTENT WITH ATLANTOAXIAL INSTABILITY (AAI).   THIS FORM MUST BE ACCOMPANIED BY A STATEMENT FROM THEIR PHYSICIAN, SIGNED AND DATED.

Primary Diagnosis____

Date of onset__________________

Secondary Diagnosis____

Date of onset__________________

Shunt Present   Yes   No   Date of last revision____

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

Braces/Assistive Devices: ____

Medications:

____

____

____

____

Participant's Name ___________________________________

Please indicate current or past special needs in the following system/areas, including surgeries. These conditions may suggest precautions and contraindications or may affect our procedures in equine assisted activities.

	Yes	No	Comments
Allergies			
Auditory			
Balance			
Cardiac			
Circulatory			
Cognitive			
Coordination			
Emotional/Psychological			
Incontinence			
Immunity			
Integumentary/Skin			
Learning Disability			
Medications			
Muscle Tone			
Neurologic			
Orthopedic			
Pain			
Pulmonary			
Seizures			
Speech			
Tactile Sensation			
Visual			
Other			

Physician's Statement

Given the above diagnosis and medical information, this person is not medically precluded from participation in equine assisted activities. I understand that the HART Equine Therapy Center, Inc. will weigh the medical information given against the existing precautions and determine eligibility for participation.

IN MY OPINION THE PATIENT NAMED ABOVE CAN RECEIVE RIDING INSTRUCTION UNDER APPROPRIATE SUPERVISION.

Name/Title ____ MD DO NP PA Other:_________

Signature ____Date ________________________

Address ____

Phone ___________________________________ License/UPIN Number______________________________

This form is valid for a period of one year from the date signed.