



PHYSICIAN PACKET

1591 Big Branch Rd.
Middleburg, FL 32068
(904) 291-6784

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*HOPE THERAPY is a Premier Accredited Center Member of:
Professional Association of Therapeutic Horsemanship International (PATH Intl.)*



(904) 291-6784
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Date: _____

Dear Health Care Provider:

Your patient is interested in participating in supervised equine activities.

(participant's name)

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 equine activities. Therefore, when completing this form, please note whether these conditions are present, and to what degree.

Orthopedic

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

Neurologic

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

Other

Age – Under 4 years
Indwelling Catheters/Medical Equipment
Medications – i.e. Photosensitivity
Poor Endurance
Skin Breakdown

Medical/Psychological

Allergies
Animal Abuse
Cardiac Condition
Physical/Sexual/Emotional Abuse
Blood Pressure Control
Dangerous to self or others
Exacerbations of medical conditions (i.e. RA, MS)
Fire Settings
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 equine assisted activities, please feel free to contact the center at the address/phone number indicated above.



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Occupational Therapy Physical Therapy Speech Therapy

PRESCRIPTION

Patient's Name: _____ DOB: _____

Diagnosis: Please check one of the following. If more than one diagnosis applies, please number in order of importance.

- | | |
|----------------------------------------------------------------|----------------------------------------------------------------------|
| <input type="checkbox"/> Hypotonia (728.9) | <input type="checkbox"/> Myelomeningocele Lumbar Region (741.93) |
| <input type="checkbox"/> Coordination Disorder (781.3) | <input type="checkbox"/> Cerebral Palsy: Spastic Diplegia (343.0) |
| <input type="checkbox"/> Apraxia / Dyspraxia (748.69) | <input type="checkbox"/> Cerebral Palsy: Spastic Hemiplegia (343.2) |
| <input type="checkbox"/> Infantile Cerebral Palsy (343.9) | <input type="checkbox"/> Developmental Coordination Disorder (315.4) |
| <input type="checkbox"/> Static Encephalopathy (349.9) | <input type="checkbox"/> Infantile Spinal Muscular Atrophy (335.0) |
| <input type="checkbox"/> Cerebellar Ataxia (334.3) | <input type="checkbox"/> Closed Head Injury (854.0) |
| <input type="checkbox"/> Other (Specify Name & ICO Code) _____ | |

CONTRADICTIONS / PRECAUTIONS

Therapy is prescribed for the following treatment:

- Gross/Fine motor coordination via neuromuscular re-education or therapeutic activities
- Gait Training
- Sensory Integrative Activities
- Perceptual Activities
- Therapeutic Exercise

Frequency: _____ Duration: _____

Physician's Name: _____

Physician's NPI number: _____

Physician's Signature: _____

Address: _____

Date: _____ Telephone: _____



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Name: _____ Date of Birth: _____

Address: _____

Name of Parent/Guardian: _____

Diagnosis: _____ Date of Onset: _____

**** For Persons with Down Syndrome:**

Negative Cervical X-ray for Atlantoaxial Instability X-ray Date: _____

Negative for clinical symptoms of Atlantoaxial Instability

Tetanus Shot: Yes No Date: _____ Height: _____ Weight: _____

Seizure

Type: _____ Controlled: _____ Date of Last Seizure: _____

Medications: _____

Please indicate if 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
Auditory			
Visual			
Speech			
Cardiac			
Circulatory			
Pulmonary			
Neurological			
Muscular			
Orthopedic			
Allergies			
Learning Disability			
Mental Impairment			
Psychological Impairment			
Other			

Mobility:

Independent Ambulation Crutches/Cane Braces Wheelchair
 Yes No Yes No Yes No Yes No

Please indicate any special precautions:



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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 review of this person's abilities/limitations by a licensed/credentialed health professional (e.g. PT, OT, Speech, Psychologist, etc.) In the implementing of an affective equestrian program.

Patient Name (please print) _____

Physician Name (please print) _____

Physician Signature _____

Address _____ City _____ State _____ Zip _____

Phone (____) _____



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