Rein-Bow Riding Academy
A service of the Therapy & Learning Center

Dear Health Care Provider:

Your patient _____

is interested in participating in supervised equine activities. This may include hippo-therapy 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

Medical/Psychological

Allergies
Cardiac Conditions
Blood Pressure Control
Exacerbations of Medical Conditions
Hemophilia
Medical Instability
Migraines
Peripheral Vascular Disease
Respiratory Compromise
Recent Surgeries

Neurologic

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

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) 664-3670 / 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 5yrs 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