Therapeutic Horsemanship

Information for Physicians:

The following conditions, if present, may represent precautions or contraindications to Therapeutic horseback riding. Therefore, when completing the form on the attached sheet, please note whether these conditions are present and to what degree.

Orthopedic Medical/Surgical

Atlantoaxial Instabilities
Allergies
Coxas Arthrosis
Cancer
Cranial Deficits
Diabetes
Heterotopic Ossification
Hemophilia
Hip Subluxation and Dislocation
Hypertension
Internal Spinal Stabilization Devices
Peripheral Vascular Disease
Kyphosis
Poor Endurance
Lordosis
Recent Surgery
Osteogenesis Imperfecta
Serious Heart Condition
Osteoporosis
Stroke (Cerebrovascular Accident)
Pathologic Fractures
Vericose Veins
Scoliosis Spinal
Orthoses
Spinal Fusion
Spinal Instabilities/Abnormalities

Neurologic Secondary Concerns

Chiari II Malformation
Acute exacerbation of chronic disorder
Hydrocephalus/shunt
Tethered Cord
Hydromyelia
Age under two years
Paralysis due to Spinal Cord injury
Behavior problems
Seizure Disorders
Indwelling catheter
Spina Bifida

Therapeutic Horsemanship

Rider's Medical History and Physician's Statement

Rider's Name _____
Name of Parent/Guardian _____
Diagnosis_____
Date of Onset_____
Tetanus Shot: (check one) YES/Date _____ NO _____
Height _____ Weight _____ lbs.
Seizure Type _____ Controlled? _____ Date of last seizure_____
Medications_____
_____

Only For Persons with Down Syndrome
Negative Cervical X-ray for Atlantoaxial Instability. Date of X-ray _____

FOR ALL RIDERS: Please indicate if patient has a problem and/or surgeries in any of the following areas by circling the items. If yes, please comment.

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

Mobility: Independent Ambulation _____Yes _____No Crutches _____Yes _____ No
Braces _____Yes _____ No Wheelchair _____ Yes _____ No

Please indicate any special precautions:_____
_____
_____
_____

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 given 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 effective equestrian program.

Physician Name (please print) _____ Date _____
Physician Signature _____
Address _____ Phone ( ) _____

Physician's Prescription
Rider's Name _____
Phone _____
Diagnosis: _____

Prescription for Therapeutic Horseback Riding

Prescription, **where appropriate** for evaluation and treatment by a Physical, Occupational and/or Speech Therapist in conjunction with the Let's Saddle Up.

Precautions (**all riders must wear helmets**)
_____
_____
_____
_____
_____

Physician's Signature _____
Date _____

Please Print, Type or Stamp
Physician's Name _____
Address _____
_____
Phone _____