Blu Flame Horsemanship

Dear Physician:

Your patient, _____ (participant's name) is interested in participating in supervised equestrian activities. 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 therapeutic horseback riding. Therefore, when completing this form, please note whether these conditions are present, and to what degree. Thank you very much for your assistance. If you have any questions or concerns regarding this patient's participation in therapeutic equine activities, please feel free to contact the center at the address/phone indicated at the bottom of the page.

Orthopedic
Atlantoaxial Instability- include neurologic symptoms
Coxa Arthrosis
Cranial Deficits
Heterotopic Ossification/Mositis Ossificans
Joint subluxation/dislocation
Osteoporosis
Pathologic Fractures
Spinal Fusion/Fixation
Spinal Instability/Abnormalities

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

Other
Age- under 4 years
Indwelling Catheters
Medications- i.e. photosensitivity
Poor Endurance
Skin Breakdown

Medical/Psychological
Allergies
Animal Abuse
Physical/Sexual/Emotional Abuse
Blood Pressure Control
Dangerous to self or others
Exacerbations of medical conditions
Fire Settings
Heart Conditions
Hemophilia
Medical Instability
Migraines
PVD
Respiratory Compromise
Recent Surgeries
Substance Abuse
Thought Control Disorders
Weight Control Disorder

PARTICIPANT'S MEDICAL HISTORY AND PHYSICIAN'S STATEMENT

Participant: _____ DOB: _____ Height: _____
Weight: _____
Address:_____

_____

Diagnosis: _____ Date of Onset:_____
Past/Prospective Surgeries:

_____

Medications:

_____

Seizure Type: _____ Controlled: Y N Date of Last Seizure:_____
Shunt Present: Y N Date of last revision:_____
Special Precautions/Needs:

_____

Mobility: Independent Ambulation Y N Assisted Ambulation Y N Wheelchair Y N
Braces/Assistive Devices:

_____

Neurologic Symptoms of AtlantoAxial Instability:

_____

Please indicate current or past difficulties in the following systems/areas, including surgeries:

	Y	N	Comments
Auditory			
Visual			
Tactile Sensation			
Speech			
Cardiac			
Circulatory			
Integumentary/Skin			
Immunity			
Pulmonary			

Neurologic			
Muscular			
Balance			
Orthopedic			
Allergies			
Learning Disability			
Cognitive			
Emotional/Psychological			
Pain			
Other			

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 implementations of an effective equestrian program.

Name/Title: _____ MD DO NP PA

Signature: _____ Date: _____

Address:_____ Phone: ( ) _____

_____ License/UPIN Number:

_____ _____