Letter to Physician

PO Box 71005, Phoenix, Arizona 85050 www.horseshelp.org Office: 602/569-6056

Dear Physician:

Your patient would like to participate in one of our Equine Assisted Activities and Learning programs at Horses Help (Program may include riding). These activities are supervised by riding and/or groundwork instructors who are certified by the Professional Association for Therapeutic Horsemanship International (PATH Intl.) and assisted by trained volunteers. Because safety is of the utmost importance, we request your evaluation of this person's appropriateness for groundwork and/or horseback riding at Horses Help.

The **following are some of the precautions/contraindications** that we take into account when considering riders for our programs. We welcome your comments, questions, and concerns. All of our participants must have an original signed and dated Physician's Release on file with Horses Help in order to participate (see reverse side for form).

ORTHOPEDIC
Atlantoaxial instability – include neurologic symptoms
Coxa arthrosis
Cranial deficits
Heterotopic ossification/Myositis 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 of age
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
Exacerbation of medical conditions
Fire setting
Heart conditions
Hemophilia
Medical instability
Migraines
PVD
Respiratory compromise
Recent surgeries
Substance abuse
Thought control disorders
Weight control disorder

We appreciate your assistance.

Horses Help
602-569-6056 (o)
602-765-7031 (f)
www.HorsesHelp.org

Physician's Release

Participant Name: ______________________________ Date of Birth: ______________ **M**ale/**F**emale _______

Address: ______________________________ City/State/Zip: ______________________________

Parent/Guardian/Care Giver: ______________________________ Phone: ______________________________

Diagnosis: ______________________________ Date of Onset: ______________________

Tetanus Shot: No Yes → Date: ___________________

Seizures: Yes No Controlled Type: _____________________ Date of Last Seizure: ____________

Medications: ____

Persons with Down Syndrome: Neurologic Symptoms of Atlantoaxial Instability: Present: ____ Absent: ____

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 - Skeletal -- ***Scoliosis Degree***			
Balance			
Shunts			
Allergies			
Learning Disability			
Mental Impairment			
Psychological Impairment			
Other			

MOBILITY:

Independent Ambulation: YES NO Braces: YES NO

Crutches: YES NO Wheelchair: YES NO

Please indicate any special precautions: ____

____

In my opinion this patient can participate in supervised equestrian activities. In conjunction with these activities, I concur in the referral of the patient to a physical/occupational therapist or other health care professional for evaluation of abilities/limitations in performing exercises and implementing an effective equestrian program.

Additionally, I certify that the height and weight listed below were measured by a member of our staff on the date this form was signed.

Patient Height ___________ **Patient Weight (taken at Physician's Office)** ____________

____
Physician's Name (PLEASE PRINT)

____
Physician's Signature ***(must be MD. PA and nurse practitioner signatures not accepted)***

Address: ______________________________ City/State: ________________________ Zip: ________

Phone: (_________) ________________________ **Date:** ___________________

THIS FORM IS VALID FOR A PERIOD OF TWO YEARS FROM THE DATE SIGNED *EXCEPT* IN CASES WHERE THE PARTICIPANT MUST SHOW PROOF OF NEGATIVE NEUROLOGICAL SYMPTOMS OF ATLANTOAXIAL INSTABILITY.
PHYSICIAN'S RELEASE MUST HAVE AN ORIGINAL SIGNATURE and DATE
RETURN TO Horses Help:
MAILING: P.O. Box 71005, Phoenix, AZ 85050 EMAIL: shelly.w@horseshelp.org