



Institute of Equestrian Therapy

A NON-PROFIT CORPORATION

PO Box 1394

Simi Valley, CA 93065

805-517-1404

www.equestriantherapy.com

PHYSICIAN'S REFERRAL

Student's Name: _____ D.O.B. _____

Street Address: _____ City _____ St. _____ Zip _____

Occupation or School: _____

Home Phone: _____ Other Phone: _____

This next section is to be filled out by the student's primary physician

Primary Diagnosis: _____

Treatment Diagnosis: _____

Date of Onset _____ Medical History _____

Surgical Procedures: _____

Medications, type and dosage: _____

Please check and/or comment on all that apply:

Visual Defects Yes[] No[] Comments: _____

Auditory Defects: Yes[] No[] Comments: _____

Speech Defects: Yes[] No[] Comments: _____

Circulation: Yes[] No[] Comments: _____

Balance: Yes[] No[] Comments: _____

Assistive Devices: Yes[] No[] Comments: _____

Seizures: Yes[] No[] Comments: _____

Incontinence: Yes[] No[] Comments: _____

Neuro-sensation: Yes[] No[] Comments: _____

Spasticity and/or Rigidity: Yes[] No[] Comments: _____

Assistive Devices/Braces Yes[] No[] Comments: _____

Limitations: Yes[] No[] Comments: _____

Other recommendations or comments: _____

(Note: Riders with Down Syndrome are required to have an x-ray reading stating the rider does not have Atlantoaxial Dislocation Condition (ADC) before being accepted into the program)

Date of Last X-Ray _____

Precautions or contraindications: _____

Please give as much information as possible:

** In my opinion, this patient can participate in horseback riding under appropriate supervision. In conjunction with the riding program, I concur in the referral of the patient to the staff or student's physical therapist for evaluation of his/her physical abilities and /or limitations in performing exercises.*

Physician's Name: _____

Address: _____

City _____ State _____ Zip _____

Phone: _____ Fax: _____ Date: _____

Signature: _____

Physical Therapist Name: _____ Address: _____

Phone: _____ Fax: _____