



A H O R S E C O N N E C T I O N

Date: _____

Dear Physician:

Your patient, (participant's name) _____ is

_____ Interested in participating in hippotherapy

_____ Interested in continuing to participating in hippotherapy

In order to safely provide this service, our program requests that you complete/update the attached Medical History and Physician's Statement form. Please note that the following conditions may suggest precautions or contraindications to hippotherapy. Therefore, when completing this form, please note whether these conditions are present, and to what degree:

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 year
- 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 Setting
- Heart conditions
- Hemophilia
- Medical Instability
- Migraines
- Peripheral Vascular Disease
- Respiratory Compromise
- Recent Surgeries
- Substance Abuse
- Thought control disorders
- Weight control disorder

Thank you very much for your assistance. If you have any questions or concerns regarding this patient's participation in hippotherapy, please feel free to contact the operating center at the address and phone number indicated above.

Sincerely,

Nancy King, MS, OTR/L



A H O R S E C O N N E C T I O N

PARTICIPANT'S MEDICAL HISTORY AND PHYSICIAN'S STATEMENT

Name: _____ Date of Birth: _____ Height: _____ Weight: _____

Address: _____

Diagnosis: _____

Past/Prospective Surgeries: _____

Medications: _____

Seizure Type: _____ Controlled?: Yes No Date of last seizure: _____

Shunt present?: Yes No Date of last revision(s): _____ Date of last Tetanus Shot: _____

Special Precautions/Needs: _____

Mobility: Independent Amulation? Yes No Assisted Ambulation? Yes No Wheelchair? Yes No

Braces/Assistive Devices: _____

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

Yes No 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 Language Pathologist, Psychologist, etc.) in the implementation of an effective equestrian program.

Name/Title: _____ MD DO NP PA Other: _____

Signature: _____ Date: _____

Address: _____ City _____ State _____ Zip _____

Phone: (____) _____ License/UPIN Number: _____