Please complete and return as soon as possible to:
HOHB Program Director
7280 Sterrettania Rd.
Fairview, PA 16415
814-474-5276
program@hopehorseback.org

Therapeutic Riding Equestrian Center

Physician's Referral

This applicant is interested in participating in supervised equine activities. In order to safely provide this service, HOHB requests that you complete/update this Medical History and Physician's Statement Form. Please note any precautions or contraindications to equine activities. Thank you for your assistance. If you have any questions or concerns regarding this patient's participation in our HOHB programs, please feel free to contact the center.

Please Print or Type

Participant _____ Date of Birth _____

Address _____ City _____ Zip_____

Phone Number: _____ Email _____

Diagnosis: _____

Cause: _____ Onset: _____

Limbs Affected: _____

If spinal cord involvement, what vertebral level? _____

Height _____ Weight _____

Current Medications: Please list any medications the patient currently takes on a regular basis:

_____

_____

_____

Please indicate if the applicant has any of the following secondary problems by checking yes or no.If yes, please include complete information pertaining to the problem.

PROBLEM	YES	NO	If yes, please describe:
Visual			
Hearing			
Sensation			
Communication			
Emotional/Mental Health			
Behavioral			
Thinking/Cognition			
Allergies			
Cardiac			Pulse: Blood Pressure:
PROBLEM	YES	NO	DESCRIPTION
Circulatory Peripheral Vascular Dis			
Pulmonary			
Metabolic/G.I. G.U. Diabetes			
Skin and Soft Tissue Pressure sore			Healed (yes no) Location
Neurological Seizures			Type Controlled (yes no) Last seizure
Hydrocephalus			Shunt (yes no)
Sensory Loss			
Surgery			
Muscular			
Pain			
Skeletal Subluxing Hips			
Dislocating Hips			
Subluxing Shoulders			
Dislocating Shoulders			
Spinal Laminectomy			
Osteoporosis			
Heterotrophic Ossific			
Spondylosis			
Spondylolisthesis			

Scoliosis			
Fractures			Degree, Type
Other (Lifting, bending or exertion Restrictions)			Location, healed?

If Down Syndrome*, are signs and symptoms of Atlantoaxial Dislocation (ADC) present as determined by an x-ray? _____Yes, signs of ADC are present _____No; signs of ADC are not present

Date of last X-ray _____

*If the patient has Downs Syndrome, please x-ray for ADC or signs and symptoms thereof. ADC is a dislocation of the joints between two cervical vertebrae, which could result in paralysis. If signs or symptoms of ADC are present, DO NOT refer the patient to Hope on Horseback for therapeutic riding.

In my opinion, this patient can receive supervised riding instruction.

Precautions or contraindications:

_____

_____

_____

Physician's Signature _____ Date: _____

Physician Name: _____ MD DO NP PA Other _____

Address: _____ City _____ State _____ Zip Code _____

Phone: _____

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