Information for Physician

The following conditions, if present, may represent precautions or contraindications to therapeutic horseback riding. Therefore when completing this form, please note whether these conditions are present, and to what degree.

Orthopedic

	Yes	No
Spinal Fusion		
Spinal Instabilities		
Spinal Abnormalities		
Scoliosis		
Kyphosis		
Lordosis		
Hip Subluxation & Dislocation		
Osteoporosis		
Pathologic Fractures		
Coxas Arthrosis		
Heterotopic Ossification		
Osteogenesis Imperfecta		
Cranial Deficits		
Spinal Orthoses		
Internal Spinal Stabilization Devices		

Medical/Surgical

	Yes	No
Allergies		
Cancer		
Poor Endurance		
Recent Surgery		
Diabetes		
Peripheral Vascular Disease		
Varicose Veins		
Hemophilia		
Hypertension		
Serious Heart Condition		
Stroke (Cerebrovascular Accident)		

Neurologic

Hydrocephalus/shunt		
Spina Bifida		
Tethered Cord		
Chiari II Malformation		
Hydromyelia		
Paralysis (spinal cord injury)		
Seizure Disorders		

Secondary Concerns

Behavior problems		
Acute exacerbation of chronic disorder		
Indwelling catheter		

Please indicate any medical problems not indicated above or if "YES" to any of the above, please describe:_____

_____

Please indicate special precautions:_____

_____

_____

Mobility Status

	Yes	No
Independent ambulation		
crutches		
braces		
wheelchair		

Please indicate special precautions:_____

Prosthetics

Type:_____ **Purpose:**_____

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 implementing of an effective equestrian program.

Physician Name (Please Print)_____

Physician Signature:_____

Address:_____**City:**_____**State:**_____**Zip:**_____

Phone:_____ **Date:**_____