Date form Completed _____

Equilibrium Therapeutic Riding Rider Application
Physician Referral Form

Name:_____ Date of Birth:_____

Address:_____

Phone (Home):_____ (Work):_____

Next of Kin/ Guardian:_____

Living at home:_____ Other:_____

Medical:
Note: It is important that this form be filled out in detail (e.g. height and weight, etc.) in order for the instructor and other professionals involved to match the rider with an appropriate mount.

Primary Diagnosis:_____

Secondary Diagnosis:_____

Height:_____ Weight:_____ Sex:_____

Diabetic:_____ Insulin:_____ Epileptic:_____

If Epileptic, frequency of seizures:_____ Date of last seizure:_____

Scoliosis:_____ Degree of Scoliosis:_____

Medications:_____

For: _____

Communicable disease?: YES NO If yes, explain:_____

Surgery: **Dates:**

_____ _____

_____ _____

Ambulatory: YES_____ NO_____

(Please complete both pages of form)

Muscle Tone (Spasticity, flaccidity etc.)

Tone in upper extremities: _____

Tone in lower extremities: _____

Tone in Trunk: _____

Balance sitting: _____ Standing:_____ Walking: _____

Language: English:_____ Sign Language:_____ Other: _____

Speech: Good:_____ Fair:_____ Poor:_____

Sensory Function: Sight:_____ Hearing: _____ Tactile:_____

Continence:_____

Allergies: _____

_____

I herby give my permission for the above individual to participate in the riding program at *Equilibrium Therapeutic Riding.*

Physicians Signature: _____ Date: _____

Physician's Name: _____

Physician's address: _____

Telephone:_____

This form is good for (physician, please check one):

_____ 1 year
_____ 2 years
_____ 5 years
_____ Life

Please be aware that all Down syndrome students with Atlanto-axial instability are required to have X-rays taken every five years until puberty in order to monitor the potential risk of life-threatening injury.

EQUILIBRIUM
therapeutic riding