Furnace Brook Farm

Therapeutic Riding
Physician Paperwork

Dear Health Care Provider:

Your patient, _____, is interested in participating in supervised equine activities.

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

Orthopedic
Atlantoaxial Instability - include neurologic symptoms
Coxarthrosis
Cranial Defects
Heterotopic Ossification/Myositis Ossificans
Joint subluxation/dislocation
Osteoporosis
Pathologic Fractures
Spinal Joint Fusion/Fixation
Spinal Joint Instability/Abnormalities

Neurologic
Hydrocephalus/Shunt
Seizure
Spina Bifida/Chiari II Malformation/Tethered Coed/Hydromyelia

Other
Age - under 4 years
Indwelling Catheters/Medical Equipment
Medications - e.g., Photosensitivity
Poor Endurance
Skin Breakdown

Medical/Psychological
Allergies
Animal Abuse
Cardiac Condition
Physical/Sexual/Emotional Abuse
Blood Pressure Control
Dangerous to Self or Others
Exacerbations of Medical Conditions (e.g., RA, MS) Fire Setting
Hemophilia
Medical Instability
Migraines
PVD
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 equine-assisted activities, please feel free to contact me.

Sincerely,
Erin VanSteenburgh
PATH Intl. Registered Therapeutic Riding Instructor
MA Department of Agriculture Riding Instructor

253 Sandy Hill Drive ◆Marshfield, MA 02050◆erinfbf@gmail.com◆ (617)650-5524

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TO BE COMPLETED BY A PHYSICIAN

Participant: _____

DOB: _____ Age: _____ Height: _____ Weight: _____

Diagnosis: _____Date of Onset: _____

Past/Prospective Surgeries: _____

_____

Medications: _____

_____

Seizures present? Y/N. If yes, type? _____ Controlled? Y/N

Date of last seizure: _____

Shunt present? Y/N. If yes, date of last revision: _____

Special Precautions/Needs: _____

_____

_____

Mobility:

Independent Ambulation Y/N Assisted Ambulation Y/N Wheelchair Y/N

Braces or assistive devices: _____

_____

For those with Down syndrome:

Neurologic Symptoms of Atlantoaxial Instability: ❑ Present ❑ Absent

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Please indicate current or past special needs in the following systems/areas, including surgeries. These conditions may suggest precautions and contraindications to equine activities.

	Y	N	Comments
Auditory			
Visual			
Tactile Sensation			
Speech			
Cardiac			
Circulatory			
Integumentary/Skin			
Immunity			
Pulmonary			
Neurologic			
Muscular			
Balance			
Orthopedic			
Allergies			
Learning Disability			
Cognitive			
Emotional/Psychological			
Pain			
Other			

Given the above diagnosis and medical information, this person is not medically precluded from participation in equine-assisted activities and/or therapies. I understand that Furnace Brook Farm will weigh the medical information given against the existing precautions and contraindications as described by PATH Intl and our center's capabilities. Therefore, I refer this person to Furnace Brook Farm for ongoing evaluation to determine eligibility for participation.

Name/Title: _____ MD DO NP PA Other _____

Signature: _____Date: _____

Address: _____

Phone: _____License/UPIN Number: _____

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