MEDICAL INFORMATION AND PHYSICIAN STATEMENT

Date:_____

Dear Healthcare Provider:

Your patient,_____, is interested in participating in the Swiftsure Ranch Therapeutic Riding Program. In order to safely provide this service, we request that you complete the attached Medical Information 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, if so, to what degree. ***If this person has Down Syndrome or any other condition that predisposes him/her to Atlantoaxial Instability, please include results of his/her most recent neurologic exam (must have been within the last year).***

Orthopedic
Atlantoaxial Instability – include neurologic symptoms
Coxa Arthrosis
Cranial Deficits
Heterotopic Ossification/Myositis Ossificans
Joint subluxation/dislocation
Osteoporosis
Pathologic Fractures
Spinal Joint Fusion/Fixation
Spinal Joint Instability/Abnormalities

Neurologic
Hydrocephalus/Shunt
Sensory Deficit
Seizure
Spina Bifida/Chiari II malformation/Tethered Cord/Hydromyelia

Other
Indwelling Catheters/Medical Equipment
Medications – i.e. 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 (i.e. RA, MS)
Fire Settings
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 about therapeutic riding activities, please email them to kristy@swiftsureranch.org

Sincerely,

Kristy Wood
PATH Certified Instructor
Swiftsure Ranch Program Manager

SWIFTSURE RANCH

Participant Name: _____

DOB: _____ Height: _____ Weight: _____

Address: _____

Diagnosis: _____ Date of Onset: _____

Past/Prospective Surgeries: _____

Medications: _____

Seizure Type:_____ Controlled: Y N Date of Last Seizure: _____

Shunt Present: Y N Date of last revision: _____ Special Precautions/Needs: _____

Mobility: Independent Ambulation Y N Assisted Ambulation Y N Wheelchair Y N
Braces/Assistive Devices: _____

For those with Down syndrome: AtlantoDens Interval X-rays Date: _____ Result + -
***Were neurologic symptoms of AtlantoAxial Instability present at this visit*? Y N Date: _____**
If yes, symptoms observed were**:** _____
_____

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

	Y	**N**	**Comments**
Auditory			
Visual			
Tactile Sensation			
Speech			
Cardiac			
Circulatory			
Integumentary/Skin			
Immunity			
Pulmonary			
Neurologic			
Muscular			
Balance			

	Y	N	Comments
Orthopedic			
Allergies			

	Y	N	Comments
Learning Disability			
Cognitive			
Emotional/Psychological			
Pain			
Other			

Given the above diagnosis and medical information, this person is <u>not</u> medically precluded from participating in equine assisted activities. I understand that Swiftsure Ranch will weigh the medical information provided against the existing precautions and contraindications. Therefore, I refer this person to Swiftsure Ranch for ongoing evaluation to determine eligibility for participation.

Name/Title:_____ MD DO NP PA Other _____

Signature:_____ **Date:** _____

Address: _____

Phone:_____ License/UPIN Number: _____

PLEASE FAX THIS FORM TO:
1 208.567.9139

Or provide it to the requesting party.