

Information for Physicians: 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

Spinal Fusion: _____
Spinal Instabilities/Abnormalities: _____
Atlantoaxial Instabilities: _____
Scoliosis: _____
Kyphosis: _____
Lordosis: _____
Hip subluxation and dislocation: _____
Osteoporosis: _____
Pathologic Fractures: _____
Coxas Arthrosis: _____
Heterotopic Ossification: _____
Osteogenesis Imperfecta: _____
Cranial Deficits: _____
Spinal Orthoses: _____
Internal Spinal Stabilization Devices: _____
Spina Bifida: _____
 Tethered Cord: _____
 Chiari II Malformation: _____
Paralysis due to Spinal Cord Injury: _____

Medical/Surgical

Allergies: _____
Cancer: _____
Poor Endurance: _____
Recent Surgery: _____
Diabetes: _____
Peripheral Vascular Disease: _____
Varicose Veins: _____
Hemophilia: _____
Hypertension: _____
Serious Heart Condition: _____
Stroke: _____
Indwelling Catheter: _____

Secondary Concerns

Behavior problems: _____
Age under two years: _____
Age two to four years: _____
Acute exacerbation of chronic disorder: _____

Neurological

Hydrocephalus/shunt: _____
Hydromyelia: _____
Seizure Disorder: _____

Special Precautions: _____

Date of Patient's Last Exam: _____

Physician's Statement

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, SLP, Psychologist, etc.) in the implementing of an effective equestrian program.

Physician's Name (please print): _____

Address: _____

Phone: _____

Physician's Signature: _____ **Date:** _____