Mounted Angels
Therapeutic Horsemanship
A Spirit Horse Center
10362 465th St. Pearl, IL 62361
HOME: 217-829-4409 CELL: 217-257-5702

Rev. 2/10/19

2019

Physician's Form

To be completed by Physician or Health Care Provider

Date: _____

Dear Health Care Provider,

Your patient, _____ (fill in rider's name)

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 Prescription 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-including 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
Seizure
Spina Bifida/Chiari 11 malformation/Tethered Cord/Hydromyelia

Medical/Psychological
Allergies
Animal Abuse
Cardiac Condition
Physical/Sexual/Emotional Abuse
Blood Pressure Control
Dangerous to self or others
Exacerbations of medical conditions (RA, MS…)
Fire Settings
Hemophilia
Medical Instability
Migraines
PVD
Respiratory Compromise
Recent Surgeries
Substance Abuse
Thought Control Disorders
Weight Control Disorder

Other
Age-under 4 years
Indwelling Catheters/Medical Equipment
Medications-i.e. photosensitivity
Poor Endurance
Skin Breakdown

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 the center at the address/phone indicated above.

Physician's Prescription

Patient's Name: _____ Phone: _____

Prescription for Therapeutic Horseback Riding

Prescription, where appropriate for evaluation and treatment by a physical, occupational and/or Speech Therapist in conjunction with the Therapeutic Horseback Riding Operating Center.

Recommended Frequency:

Precautions:

Physician's Signature: _____ Date: _____

Please complete back of page.

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Physician's Form

Participant's Medical History and Physician's Statement continued.
Participant: _____ 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 (required): AtlantoDens Interval X-rays, date: _____Result: + -
Neurologic Symptoms of AtlantoAxial Instability: _____
Please indicate current or past special needs in the following systems/area, including surgeries:

	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. I understand that the Spirit Horse center will weigh the medical information given against the existing precautions and contraindications. Therefore, I refer this person to the Spirit Horse center for ongoing evaluation to determine eligibility for participation.

Name/Title: _____MD DO NP PA Other_____

Signature: _____Date: _____

Address: _____

Phone: _____ License/UPIN Number:_____