Rise Up Therapeutic Horsemanship

Doctor's Recommendation 2019

(To be completed by participant's physician)

Dear Physician, Date_____

Your patient,_____ would like to participate in equine- assisted activities and therapies (EAAT).

So that we can provide a safe and appropriate program, Rise Up Therapeutic Horsemanship requests the completed attached Medical Recommendation Form. Please note that there exist within some medical conditions serious precautions and contraindications to therapeutic horsemanship. With that in mind, please carefully consider whether and to what degree such conditions are present. Please fill out the appropriate sections below.

DOB_____ Height_____
Weight____ _
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_____. _
Date of last Hip Radiograph_____ Result (please describe)_____
Special precautions/needs_____
_____

Mobility:
Independent Ambulation Y N
Assisted Ambulation Y N
Wheelchair Y N
Braces/assistive

devices
_____

For those with Down Syndrome:
Atlanto Dens X-Rays, date Result: +
Neurologic symptoms of AtlantoAxial Instability _
_____

Rise Up Therapeutic Horsemanship

Doctor's Recommendation p.2

Participant name_____ **DOB**_____

Current patient medications- Please list:

_____
_____
_____
_____

Do you suggest specific goals for this client?

_____

_____
_____

Is there any pertinent further information **Rise Up Therapeutic Horsemanship** should consider when making an EAAT plan for this client? Please include, in the space below, any specifics concerning diagnoses for this individual, not listed on the other forms, as well as any indications or contraindications to horseback riding as an activity for this individual.

After careful review of _____(patient name) medical history and consideration of the risks involved, to my knowledge there is no reason why this person cannot participate in supervised Equine Assisted Activities and Therapy.

Signature_____Title_____

Printed Name_____Date_____

License /UPIN #_____

Office and Address_____

_____

Phone #_____

Rise Up Therapeutic Horsemanship

Doctor's Recommendation p.3

Participant Name_____ **DOB**_____

Please indicate current or past issues, or completed procedures:	Yes	No	Comments
Auditory			
Visual			
Tactile Sensation			
Speech			
Cardiac			
Circulatory			
Skin			
Immunity			
Pulmonary			
Neurologic			
Muscular			
Balance			
Orthopedic			
Allergies			
Learning Disability			
Cognitive			
Emotional/Psychological			
Pain			
Other			

Rise Up Therapeutic Horsemanship

Doctor's Recommendation p.4

Participant Name_____ DOB_____

Please note which of the following conditions are present, and, if applicable, to what degree.

Orthopedic

____Atlantoaxial instability (include neurological symptoms)
____Hydrocephalus/shunt
____Coxa Arthrosis
____Cranial Defects
____Heterotropic ossification/Myosotis Ossificans malformation
____Joint subluxation/dislocation
____Osteoporosis
____Pathological Fractures
____Spinal Fusion/Fixation
____Spinal Instabilities/abnormalities

Medical/Psychological

____Allergies
____Animal Abuse
____Physical/Sexual/Emotional Abuse
____Blood Pressure control
____Dangerous to self or others
____Exacerbations of medical conditions
____Heart Conditions
____Hemophilia
____Medical Instability
____Migraines
____PTSD
____PVD
____Respiratory Compromise
____Recent surgeries
____Substance Abuse
____Type I or II Diabetes (please specify)
____Varicose veins
____Weight control disorder

Neurological

____Seizures
____Spina Bifida
____Chiari II
____Tethered Cord
____Hydromyelia