RETURN COMPLETED FORM TO:

Riding Beyond
PO Box 1281
Ashland, OR 97520

541.482.6210
ridingbeyond@gmail.com

Dear Health Care Provider:

Your patient

is interested in participating in supervised equine activities.

In order to safely provide this service, our program requests that you complete/update 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

Medical/Psychological

Allergies
Weight Control Disorder
Cardiac Condition
Thought Control Disorders
Blood Pressure Control
Dangerous to Self or Others
Exacerbations of Medical Conditions (e.g., RA, MS)
Substance Abuse
Hemophilia
Medical Instability
Migraines
PVD
Respiratory Compromise
Recent Surgeries

Other

Indwelling Catheters/Medical Equipment
Medications - e.g., 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 me at the address/phone indicated above.

Sincerely,

Trish Broersma
Director, Riding Beyond

Participant's Medical History & Physician's Statement

Participant: _____ DOB: _____ Height: _____ Weight: _____

Address: _____

Diagnosis: _____ Date of Onset: _ _____

Past/Prospective Surgeries: _____

Medications: _____

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

Special Precautions/Needs: _____

_____

Mobility: Independent Ambulation Y N Assisted Ambulation Y N Wheelchair Y N

Braces/Assistive Devices: _____

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

Name/Title: _____ MD DO NP PA Other _____

Signature: _____ Date: _____

Address: _____

Phone: ( ) License/UPIN Number: _____