Special Equestrians, Inc.

PO Box 61528
Fort Myers, FL 33906-1528
telephone: 239.226.1221
fax: 239.226.1279
email: spequestrians@gmail.com
website: www.specialequestrians.net

Information for Health Care Provider

Dear Health Care Provider:

Your patient is interested in participating in supervised equine activities. In order to safely provide this service, Special Equestrians requests that you complete/update the Information for Health Care Provider Form and the Medical History and Physician's Statement Form. Please note that the following conditions may suggest precautions and contraindications to equine activities. When completing this form, please note whether these conditions are present, and to what degree. **Please include the patient's current weight. This information is very important in determining a suitable horse for a participant in our therapeutic horseback riding program.**

PATIENT'S NAME _____ **Date** _____

ORTHOPEDIC	**COMMENTS**	**MEDICAL/PSYCHOLOGICAL**	**COMMENTS**
Atlantoaxial Instability		Allergies	
Coxarthrosis		Animal Abuse	
Cranial Deficits		Cardiac Condition	
Heterotopic Ossification/Myositis Ossicans		Physical/Sexual/Emotional Abuse	
Joint subluxation/dislocation		Blood Pressure Control	
Osteoporosis		Dangerous to self or others	
Pathologic Fractures		Respiratory Compromise	
Spinal Joint Fusion/Fixation		Fire Setting	
Spinal Joint Instability/Abnormalities		Hemophilia	
		Medical Instability	
NEUROLOGIC		Migraines	
Hydrocephalus/Shunt		PVD	
Seizure		Substance Abuse	
Spina Bifida/ Chiari II Malformation/ Tethered Cord/ Hydromyelia		Exacerbations of medical conditions (e.g. RA, MS)	
		Weight Control Disorder	
OTHER		Thought Control Disorders	
Age - under 4 years		Recent Surgeries	
Medications - i.e. photosensitivity			
Poor Endurance			
Skin Breakdown			
Indwelling Catheters/Medical Equipment			

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 (239) 226-1221.

Sincerely,

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Participant's Medical History & Physician's Statement

Participant:_____ **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:_____

Special Precautions/Needs:_____

Spasticity or Rigidity: Y N _____

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

Braces/Assistive Devices:_____

For those with Down syndrome: **Neurologic Symptoms of AtlantoAxial Instability:** _____ Present _____Absent

Please indicate current or past special needs in the following systems/areas, including surgeries. These conditions may suggest precautions and contraindications to equine activities.

SYSTEM / AREA	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			

*****SIGN AND DATE THIS FORM BELOW *****

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

Name/Title:_____ MD DO NP PA Other_____

Signature:_____ **Date**:_____

Address:_____ City:_____ State:___ Zip: _____

Phone: ( )_____ **License/NPI Number**_____