BLUE MOUNTAIN THERAPEUTIC RIDING
1150 VALLEY ST
WALLA WALLA, WASHINGTON 99362

Mailing Address: PO BOX 761, College Place, WA 99324

PHYSICIAN'S REFERRAL

{PLEASE FILL OUT THIS FORM THOROUGHLY AND COMPLETELY]

Patient Name: ____

Date of Birth:______________________Height:_________________Weight:______________________________

Disabling Condition (Diagnosis):____

____Date of Onset:_____________________

Limbs affected: ____

If SPINA BIFIDA or other Spinal Cord involvement - what level vertebrae? ______________________________

____

If DOWNS SYNDROME - before riding, all patients must have a medical examination and lateral - view roentgenograms of the upper cervical region in neutral, full flexion and extension positions. All patients under 20 years of age must have an examination and roentgenograms every two years for riding.

Date of last examination and roentgenograms:__________________Did they reveal Atlantoaxial Instability or Neurological Disorder? ______________________

Current Medical History: ____

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Surgical Procedures:____

____Date:______________________________

Current Medication:____

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Does the patient use: Braces______Cane_____Crutches_____Walker_____Wheelchair_____Hearing Aid_______

Other (specify):____

Does the patient have any other problems, which may affect his/her ability to ride? Check and describe below.

_____Auditory
_____Speech
_____Vision
_____Circulation
_____Balance and Coordination
_____Acute stages of arthritis
_____Incontinence
_____Pain
_____Hemophilia
_____Spasticity and/or rigidity
_____Pathological fractures
_____Serious heart condition
_____Ataxia or apraxia
_____Allergies
_____Osteoporosis
_____Orthopedic limitations
_____Unstable spine
_____Open pressure sores or open wounds
_____Hip subluxation or dislocation
_____Primitive or pathological reflexes
_____Psychological (include IQ where pertinent)
_____Structural Scoliosis greater than 30 degrees
_____Guillian-Barre or Multiple Sclerosis with poor endurance
_____Seizures___________Have been controlled for at least a year
_____Overweight or under weight
_____Other

Please describe the problems checked: ____

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Precautions or contraindications to physical activity:

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Date:_____________________________Physicians Name (PRINT):______________________________________

Address: ____

____Telephone:______________________________

In my opinion, this patient can receive therapeutic riding instruction under appropriate supervision

Physicians Signature:____