Blue Mountain Therapeutic Riding
Mailing Address: PO Box 761 | College Place, WA 99324
Program Location: 1150 Valley Street | Walla Walla, WA 99362
509.542.7624 | mary@bluemountaintherapeuticriding.org
EIN: 46-2458128

Date: _____

Dear Health Care Provider:

Your patient _____

(Participant's name)

Is interested in participating in supervised equine activities.

In order to safely provide this service, our center 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 where 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
Spina Bifida/Chiari II Malformation/Tethered Cord/Hydromyelia

Other

Age – Under 4 years
Indwelling Catheters/Medical Equipment
Medications – e.g. Photosensitivity

Other Continued

Poor Endurance
Skin Breakdown

Medical/Psychological

Allergies
Animal Abuse
Cardiac Condition
Physical/Sexual/Emotional Abuse
Blood Pressure Control
Dangerous to Self or Others
Exacerbations of Medical Conditions (eg RA, MS)
Fire Setting
Hemophilia
Medical Instability
Migraines
PVD
Respiratory Compromise
Recent Surgeries
Substance Abuse
Thought Control Disorders
Weigh Control Disorder

Thank you very much for your assistance. If you have any questions or concerns regarding this patient's participation in equine-assisted services, please feel free to contact at the address/phone indicated above.

Sincerely,
Mary Murphy, CTRI

Blue Mountain Therapeutic Riding
Mailing Address: PO Box 761 | College Place, WA 99324
Program Location: 1150 Valley Street | Walla Walla, WA 99362
509.542.7624 | mary@bluemountaintherapeuticriding.org
EIN: 46-2458128

MEDICAL HISTORY and PHYSICIAN'S STATEMENT

{PLEASE FILL OUT THIS FORM THOROUGHLY AND COMPLETELY]

Patient_____DOB:_____Height:_____Weight_____

Address:_____

Disabling Condition (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/Assisted 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.

	Y	N	Comments
Auditory			
Visual			
Tactile Sensation			
Speech			
Cardiac			
Circulatory			
Integumentary/Skin			
Immunity			
Pulmonary			
Neurologic			
Muscular			
Balance			
Orthopedic			
Allergies			
Learning Disability			
Cognitive			

Blue Mountain Therapeutic Riding
Mailing Address: PO Box 761 | College Place, WA 99324
Program Location: 1150 Valley Street | Walla Walla, WA 99362
509.542.7624 | mary@bluemountaintherapeuticriding.org
EIN: 46-2458128

	Y	N	Comments
Emotional/Psychological			
Pain			
Other			

Given the above diagnosis and medical information, this person is not medically precluded from participation in equine-assisted services. I understand that the Professional Association of Therapeutic Horsemanship, Intl (PATH, Intl) Center will weigh the medical information given against the existing precautions and contraindications. Therefore, I refer this person to Blue Mountain Therapeutic Riding for ongoing evaluation to determine eligibility for participation.

Name/Title:_____MD DO NP PA

Signature:_____

Adress:_____

Phone (___)_____License/UPS Number:_____