

# ACCESS ADVENTURE

*Challenging the Limits of Disability*

P. O Box 2852, Fairfield, CA 94533

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## Physician Referral Form

Student: \_\_\_\_\_

DOB: \_\_\_\_\_ Age: \_\_\_\_\_ Height: \_\_\_\_\_ Weight: \_\_\_\_\_ Male: \_\_\_\_\_ Female: \_\_\_\_\_

Address: \_\_\_\_\_

Diagnosis: \_\_\_\_\_ Date of Onset: \_\_\_\_\_

Past/Prospective Surgeries: \_\_\_\_\_

Medications: \_\_\_\_\_

Seizure Type: \_\_\_\_\_ Controlled:  Y  N Date of Onset: \_\_\_\_\_

Shunt Present:  Y  N Date of Last Revision: \_\_\_\_\_

Special Precautions/Needs: \_\_\_\_\_

Mobility:  Independent Ambulation  Assisted Ambulation  Wheelchair

Braces/Assistive Devices: \_\_\_\_\_

For those with Down Syndrome: AtlantosDens Interval X-rays – Date \_\_\_\_\_ Result:  positive  negative

Neurologic Symptoms of AltatoAxial Instability: \_\_\_\_\_

**Please indicate current or past difficulties in the following system/areas, including surgeries:**

	Y	N	COMMENTS
Auditory			
Visual			
Tactile Sensation			
Speech			
Cardiac			
Circulatory			
Integumentary/Skin			
Immunity			
Pulmonary			
Neurologic			
Muscular			
Balance			
Orthopedic			
Allergies			
Learning Disabilities			
Cognitive			
Emotional/Psychological			
Pain			
Other			

To my knowledge, there is no reason why this person cannot participate in supervised equestrian activities. However, I understand that the therapeutic riding center will weigh the medical information above against the existing precautions and contraindications. I concur with a review of this person's abilities/limitations by a licensed/credentialed health professional (e.g. PT, OT, Speech, Psychologist, etc.) in the implementations of an effective equestrian program.

Name/Title: \_\_\_\_\_ MD DO NP PA Other: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_ License/UPIN: \_\_\_\_\_

**PLEASE CAREFULLY READ PRECAUTIONS AND CONTRAINDICATIONS ON REVERSE**

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**Please note that the following conditions may suggest precautions and contraindications to Equine Facilitated Therapies. Therefore, when completing this form, please note whether these conditions are present, and to what degree.**

### **Orthopedic**

Atlantoaxial Instability – include neurologic symptoms

Coxa Arthrosis

Cranial Deficits

Heterotopic Ossification/Myositis Ossificans

Joint subluxation/dislocation

Osteoporosis

Pathologic Fractures

Spinal Fusion/Fixation

Spinal Instability/Abnormalities

### **Neurologic**

Hydrocephalus/Shunt

Seizure

Spina Bifida/Chiari II Malformation/Tethered Cord/Hydromyelia

### **Medical/Psychological**

Allergies

Animal Abuse

Physical/Sexual/Emotional Abuse

Blood Pressure Control

Dangerous to self or others

Exacerbations of medical conditions

Fire Settings

Heart Conditions

Hemophilia

Medical Instability

Migraines

PVD

Respiratory Compromise

Recent Surgeries

Substance Abuse

Thought Control Disorders

Weight Control Disorder

### **Other**

Age – under 4 years

Indwelling Catheters

Medications – i.e., photosensitivity

Poor Endurance

Skin Breakdown