YEAR:

FREDERICK COUNTY 4-H THERAPEUTIC RIDING PROGRAM

PHYSICIAN'S REFERRAL

{PLEASE FILL OUT THIS FORM THOROUGHLY AND COMPLETELY]

Patient Name: _____

Date of Birth: _____Height _____ Weight _____

Handicapping 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 _____

_____

_____

Surgical Procedures_____

_____Date_____

Current Medication_____

_____

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 on the back of the page.

_____Auditory	_____Incontinence	_____Ataxia or apraxia
_____Speech	_____Pain	_____Allergies
_____Vision	_____Hemophilia	_____Osteoporosis
_____Circulation	_____Spasticity and/or rigidity	_____Orthopedic limitations
_____Balance and Coordination	_____Pathological fractures	_____Unstable spine
_____Acute stages of arthritis	_____Serious heart condition	
_____Open pressure sores or open wounds		

PLEASE FILL OUR REVERSE PAGE

_____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 _____

_____

_____

_____

_____

In my opinion, this patient can receive riding instruction under appropriate supervision. In concur in the referral of the patient to your Program Therapist for evaluation of his/her physical abilities and/or limitations in performing exercises.

Precautions or contraindications to physical activity _____

_____

_____

Date: _____Physicians Name (PRINT)_____

Address _____

_____

Telephone _____

Physicians Signature_____

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