Physician's Referral

Participant: _____ DOB: _____ Height: _____ Weight: _____
Address: _____
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: Atlanto Dens Interval X-ray, date: _____ Result: + -
Neurological Symptoms of Atlanto Axial Instability: _____
Please indicate current or past special needs in the following systems/areas, including surgeries:

	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			

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 Ivey Ranch Park Assoc. will weigh the medical information given against the existing precautions and contraindications. Therefore, I refer this person to the Ivey Ranch Park Equestrian Programs for ongoing evaluation to determine eligibility for participation.

Name/Title: _____ MD DO NP PA Other _____

Signature: _____ Date: _____

Address: _____

Phone: (___) _____ License/UPIN Number: _____