RTRA
Regina Therapeutic Riding Association

ATLANTO-AXIAL X-RAY VERIFICATION FOR RIDERS WITH DOWN SYNDROME

Name of Client _____Date of birth _____

Address: _____

Telephone: (_____)_____Cell: (_____)_____

Height: _____ Weight: _____

Name of Physician: _____

Address: _____

Name and Address of X-ray Dept/Clinic if different from above:

_____

Telephone: _____ Fax: _____

Date of X-Ray: _____

Results: _____

Physician's Signature: _____

Note: Due to the nature of this activity, persons diagnosed with Down Syndrome cannot be accepted into the Therapeutic Riding Program without proof of a negative diagnostic X-ray for Atlanto-Axial Instability. This form must be accompanied by a signed and dated statement from a qualified Physician, including the date and result of the X-ray.