PHYSICIAN REFERRAL FORM

*Information is kept confidential and reviewed by the RTRA's Medical Advisor, Physiotherapist and Instructor/or Instructors, for a Riding Program assessment.

Name: _____ Birth date: _____
(client)
Address: _____
(Apt, City, Postal Code)

Parent(s) or Guardian(s): _____

Address: _____
(If different from above)

Home phone: (____) _____ Work: (____)_____

Cell: (____)_____ email: _____

Primary Diagnosis: Date of onset:

Secondary Diagnosis: Date of onset:

Height: Weight: Diabetic: Insulin:

Ambulatory: **Y** or **N** If no, please indicate aids used:

Epileptic: **Y** or **N** If yes, please indicate type, frequency and date of last seizure:

General Health:

Communicable Disease: **Y** or **N** If yes, please explain:

Allergies: **Y** or **N** If yes, please indicate:

Previous Surgeries and dates:

MEDICATIONS

Prescription/non-prescription: Use:

Tone: Upper extremities Lower extremities

Trunk

Balance: Sitting Standing Walking

Language: English Other Sign Language

Speech: Good Fair Poor Non-verbal

Ability to Understand: Good Fair Poor

Sensory Function: Sight Hearing Tactile

Continence:

Briefly describe any intellectual or emotional problems which may affect participation in this program or any other comments you might find useful in planning an individual riding program for this client.

Understanding that riding is a risk activity, I feel the possible benefits are greater than the possible risks. In my opinion, the patient named above may participate in the **Regina Therapeutic Riding Program.**

Physician _____
(please print clearly)

Signature _____ **Date _____**

Address _____

Phone (_____)_____ , Fax (_____)_____, Email _____

PLEASE USE CLINIC STAMP IF AVAILABLE