Powell River Therapeutic Riding Association

4356 Myrtle Avenue, Powell River, BC, V8A 0T2

Phone: 604-485-0177, Email: prtravolunteer@gmail.com

Please mail this completed form to Powell River Therapeutic Riding at the above address, or email to prtravolunteer@gmail.com

Notice to Physicians

The following conditions may represent precautions or contradictions to therapeutic horseback riding, If present in potential students. Please not whether or not these conditions are present, and to what degree.

Absolute Contraindications to Therapeutic Riding

Orthopaedic:

Acute arthritis
Acute herniated disk or prolapsed disc
Atlanto-axial instability
Coxarthrosis (degeneration of the hip joint) or dislocation, subluxation or dysplasia of hip
Structural cranial deficits
Osteoporosis (severe)
Pathological fractures (eg. – osteogenesis imperfecta)
Spondylolisthesis
Structural scoliosis greater than 30 degrees or excessive kyphosis or lordosis;
Hemivertebrae
Unstable spine including subluxation (partial dislocation) of the cervical vertebrae.
Heterotopic ossification

Neurological

Anti-coagulant medication
CVA
- Secondary to unclipped aneurysm, or presence of other aneurysms
- Secondary to angioma that was not totally resected

Drug dosages causing physical states inappropriate to riding environment
Craniotomy
Exacerbation of multiple sclerosis
Hemophilia
Open sores and/or wounds on contact surfaces
Seizures within the last 6 months
Spina bifida associations – Chiari II malformations, hydromyelia, tethered cord
Paralysis due to spinal cord injury above T6

Other

Weight Limit: 180 lbs
Any condition that the instructor or program does not feel comfortable teaching

Relative Contraindications and Precautions

Orthopedic:

- Arthrogryposis
- Heterotopic Ossification
- Spinal fusion/fixation, Harington rod (within two years of surgery)
- Spinal instabilities/abnormalities
- Spinal orthoses
- Anticoagulants (Bleeding risk)

Neurological:

- Amyotrophic lateral sclerosis
- Fibromyalgia
- Guillain-Barre syndrome
- Exacerbation of multiple sclerosis
- Post-polio syndrome
- Hydrocephalic shunt

Medical/psychosocial:

- Abusive or disruptive behavior
- Cancer
- Hemophilia
- History of skin breakdown or skin grafts
- Abnormal fatigue
- Incontinence
- Peripheral vascular disease
- Sensory Deficits
- Serious heart condition or hypertension
- Surgery within the last three months
- Uncontrolled diabetes
- In-Dwelling catheter

Thank you for taking the time to read our contraindications and precautions. Please keep these in mind as you are filling out the referral forms. Your comments will greatly help our instructors provide a better quality program for the applicant. Where possible, please be specific with your comments. If you have any questions or concerns regarding your patient's participation in our program, or have any questions about PRTRA or therapeutic riding in general, please do not hesitate to call our office.

Sincerely,
Powell River Therapeutic Riding Association

Physician's Referral

Name: _____ Birthdate: _____

Care Card Number: _____ Parent/Legal Guardian: _____

Address: _____ Postal Code: _____

Diagnosis: _____ Date of Onset: _____

Medical History: _____

_____

Weight: _____ *(Please note we do have a weight limit – maximum is 180lbs)* Height:_____

Psychological: _____

Medications: _____

Medication Side Effects: _____

Allergies: _____

Visual Limitations: _____ Auditory Limitations: _____

Speech Limitations: _____

Circulation: _____ Neuro Sensation: _____

Balance: _____ Coordination: _____

Spasticity and/or Rigidity: _____

Medical History

Problem	Yes	No	If Yes, Describe
Atlanto-axial instability			**Date of last x-ray:_____**
Neurological Seizures			**Controlled by medication: Yes ___ No ___ Last Seizure Type_____ Date of Last seizure:_____**
Hydrocephalus			
Sensory Loss			
Shunt?			
Muscular			
Contractures			
Skeletal			
Subluxing hips			
Dislocating hips			
Spinal Laminectomy			
Scoliosis			**Degree_____Type_____ Last X-ray_____**
Kyphosis, Lordosis			**Degree_____Type_____**
Spondylosis			
Osteoporosis			
Heterotrophic Ossif.			
Arthrodesis			
Fractures			**Locations_____Healed?**
Harrington Rods			**Date of Surgery_____**
Other or Special Precautions			

Mobility Status:

Can the student ambulate: Yes: ___ No: ___

Assistance: Independent _____ Minimal _____ Moderate ____ Maximal _____

One person assist _____ Two person assist ____

Physical Aids: Canes _____ Crutches _____ Walker _____ Rolling Walker _____

Braces (type) _____

Other (i.e. Splints) describe _____

Does the student use a wheelchair? If Yes, Type _____

Can the student propel the wheelchair? _____

Please describe any additional information that might help us to work with this student.

Thank you for your time *(use the back of this page if more space is required).*

In my opinion, this patient can receive therapeutic horseback riding lessons under proper instruction:

Physician's Signature: _____ Name (please print):_____

Address: _____ Phone: _____

Phone: _____ Date:_____

Re-evaluation by physician may be necessary. If yes, please give date for re-evaluation:_____