Date: ______________________

Powell River Therapeutic Riding Association
4356 Myrtle Avenue
Powell River, B.C. V8A 0T2

Notice to Physicians

Client's Name and Phone Number: ____

Please mail this completed form to Powell River Therapeutic Riding at the above address or FAX: 604-485-0178.

Contraindications to Therapeutic Riding

Orthopaedic

Acute herniated disk
Atlanto-axial instability
Coxa arthrosis (degeneration of the hip joint) or dislocation, subluxation or dysplasia of hip
Osteoporosis (severe)
Pathological fractures (eg. – osteogenesis imperfecta)
Spinal fusion, organic or operative (eg. – Harrington rods)
Spondylolisthesis
Structural scoliosos greater than 25 – 30 degrees or excessive kyphosis or lordosis; hemivertebrae
Unstable spine including subluxation (partial dislocation) of the cervical vertebrae.
Heterotopic ossification

Medical

Acute stage of arthritis
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
Uncontrolled seizures

Other

Any patient you are not completely (competent/safe) treating
Complete quadriplegia secondary to spinal cord injury
Moderate agitation with severe confusion/gross disruptive behaviour
Recent surgery
Weight Limit: 180 lbs.

Revised: November 28, 2019

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 – Max. is 180lbs)

Psychological: ____

____

Medications: ____

Allergies: ____

Visual Limitations: ____________________ Auditory Limitations: ____________________

Speech Limitations: ____________________

Circulation: ________________________ Neuro Sensation: ____________________

Balance: ____________________________ Co-Ordination: ______________________

Spasticity and/or Rigidity: ____

Physician's Prescription for Therapeutic Horseback Riding and, where appropriate, for evaluation and treatment by a Physical/Occupational Therapist.

Precautions: ____

Physician's Signature: ________________________ Date: ________________________

Please Print: Physician's Name: ____

Address: ________________________________ Phone: ____________

Revised: November 28, 2019

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

Medical History

Problem	**Yes**	**No**	**If Yes, Describe**
Neurological Seizures			Controlled (Yes ___ No ___ Last Seizure Type
Hydrocephalus			
Sensory Loss			
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?
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.)

Physician's Signature: ____________________________ Name (please print):_______________________

Phone: ___________________________ Date:______________________________