Powell River Therapeutic Riding Association

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

Phone: 604-485-0177 e-mail: prtravolunteer@gmail.com

Notice to Physicians

Please mail this completed form to Powell River Therapeutic Riding at the above address, email to prtravolunteer@gmail.com or fax to 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 September 16, 2020

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)*

Psychological: _____

Medications: _____

Allergies: _____

Visual Limitations: _____ Auditory Limitations: _____

Speech Limitations: _____

Circulation: _____ Neuro Sensation: _____

Balance: _____ Coordination: _____

Spasticity and/or Rigidity: _____

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Medical History

Problem	Yes	No	If Yes, Describe
Atlanto-axial instability			Date of last x-ray
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):_____

Address: _____ Phone: _____

Phone: _____ Date:_____

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

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