Promise Ranch Therapeutic Riding
6230 East Highway 86
Franktown, CO 80116
(303) 817-6531
prtr.org

Dear Health Care Provider:

Your patient is interested in participating in supervised equine activities/therapies. In order to safely provide this service, Promise Ranch requests that you complete/update the attached Medical History and Physician's Statement Form. Please note that the following conditions may suggest precautions and contraindications to equine activities/therapies. Therefore, when completing this form, please note whether these conditions are present, and to what degree.

Orthopedic

- Atlantoaxial Instability – include neurologic symptoms
- Heterotopic Ossification/Myositis Ossificans
- Joint Subluxation/Dislocation
- Pathologic Fractures
- Spinal Instability/Abnormalities
- Coxarthrosis
- Cranial Defects/Deficits
- Osteoporosis
- Spinal Joint Fusion/Fixation

Neurologic

- Hydrocephalus/Shunt
- Spina Bifida/Chiari II Malformation/Tethered Cord/Hydromyelia
- Seizure

Medical/Psychological

- Allergies
- Cardiac Condition
- Blood Pressure Control
- Exacerbations of Medical Conditions (i.e. RA, MS)
- Hemophilia
- Migraines
- Respiratory Compromise
- Substance Abuse
- Weight Control Disorders
- Animal Abuse
- Physical/Sexual/Emotional Abuse
- Dangerous to Self or Others
- Fire Setting
- Medical Instability
- Peripheral Vascular Disease
- Recent Surgeries
- Thought Control Disorders

Other:

- Age – less than 4 years
- Medications (i.e. Photosensitivity)
- Skin Breakdown
- Indwelling catheters/Medical Equipment
- Poor Endurance

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Medical History and Physician's Statement

Participant: _____

D.O.B.:_____ Height: _____

Weight:_____ Gender: _____

Primary Diagnosis: _____

Date of Onset: _____

Secondary Diagnosis: _____

Date of Onset: _____

Past Surgeries: _____

Prospective surgeries: _____

Medications and purposes:

_____

_____

_____

Seizures: Yes ☐ No ☐ Controlled? Yes ☐ No ☐

Type:_____ Date of Last Seizure: _____

Shunt Present: Yes ☐ No ☐ Date of Last Revision: _____

Special Precautions/Needs: _____

Mobility: Independent Ambulation Yes ☐ No ☐ Assisted Ambulation Yes ☐ No ☐

Wheelchair Yes ☐ No ☐ Braces/Assistive Devices: _____

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FOR INDIVIDUALS WITH DOWN SYNDROME ONLY:

Because of the nature of horseback riding, no individual diagnosed with Down Syndrome can be accepted for any equine assisted activity or therapy without proof of a negative diagnostic X-ray for Atlantoaxial Instability.

Physician's Acknowledgement:

I have X-rayed this patient for Atlantoaxial Instability and the results are negative. In addition, this patient does not display any neurologic signs or symptoms of this condition and may participate in the Promise Ranch Therapeutic Riding Program.

Date of last X-ray: _____

Physician Signature: _____Date: _____

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Please indicate current or past special needs in the following systems/areas:

	Y	N	Comments
Auditory	☐	☐	
Visual	☐	☐	
Tactile sensation	☐	☐	
Speech/Language	☐	☐	
Cardiac	☐	☐	
Circulatory	☐	☐	
Psychological/Emotional/Behavioral	☐	☐	
Integumentary/Skin	☐	☐	
Immunity	☐	☐	
Pulmonary	☐	☐	
Neurologic	☐	☐	
Muscular	☐	☐	
Balance	☐	☐	
Orthopedic	☐	☐	
Allergies	☐	☐	
Learning & Development	☐	☐	
Cognitive	☐	☐	
Pain	☐	☐	
Other	☐	☐	

Given the above diagnosis and medical information:
☐ **Yes**, in my opinion this patient can participate in the Promise Ranch Therapeutic Riding Program, under appropriate supervision.

☐ **No**, in my opinion this patient should not participate in the Promise Ranch Therapeutic Riding Program.

Authorization

Signature: _____ Date: _____

Name/Title:_____MD/DO/NP/PA/Other: _____

Address: _____

Phone:_____

License/UPIN Number:_____

Promise Ranch Therapeutic Riding is a 501(c)3 tax exempt organization. For your record keeping purposes, our tax ID # is:26-2431767. Mailing address: P.O. Box 545, Franktown, CO 80116