Promise Ranch Therapies & Recreation
873 Lake Gulch Road
Castle Rock, CO 80104
(303) 817-6531
www.PRTR.org

Dear Healthcare 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
· Coxarthrosis
· Heterotopic Ossification/Myositis Ossificans · Cranial Defects/Deficits
· Joint Subluxation/Dislocation · Osteoporosis · Pathologic Fractures
· Spinal Joint Fusion/Fixation · Spinal Instability/Abnormalities

Neurologic

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

Medical·

· Allergies ·Hemophilia · Medical Instability · Migraines · Peripheral Vascular Disease ·
· Respiratory Compromise · Recent Surgeries · · Weight Control Disorders
· Blood Pressure Control · Exacerbations of Medical Conditions (i.e. RA, MS)

Psychological

· Animal Abuse · Cardiac Condition · Physical/Sexual/Emotional Abuse
· Fire Setting · Dangerous to Self or Others · Substance Abuse
· Thought Control Disorder

Other:

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

Please complete the following forms on pages 2-4 and give them to your patient to return to Promise Ranch.
Thank you!

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: _________________

Mobility type: Independent Assisted Ambulation Wheelchair

Braces/Assistive Devices: _________________________________

Special Precautions/Needs: ____

Continued on next page

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

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

Physician's Statement continued on next page

Physician's Authorization

Given the patient's diagnosis and medical information:
_____ **Yes**, in my opinion this patient can participate in the Promise Ranch Adaptive Riding Program or Hippotherapy, under appropriate supervision.

______**No**, in my opinion this patient should not participate in the Program.

Physician's Information

Signature: ____ Date: _______________

Name/Title:_______________________________________ MD/DO/NP/PA/Other: _______

Business Address:____

Phone:____

License/UPIN Number:____

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 Adaptive Riding or Hippotherapy Program.

Date of last X-ray: ____

Physician Signature: ____Date: ____________