LADAWN QUARTER HORSES THERAPEUTIC RIDING CENTER
P.O. Box 558
WEST KENNEBUNK, ME 04094
207-499-0080
Fax # 207-499-2597

PHYSICIAN'S REFERRAL

NAME _____
PARENT/ GUARDIAN_____
ADDRESS _____
DATE OF BIRTH _____
HEIGHT _____ WEIGHT _____

LADAWN QUARTER HORSES THERAPEUTIC RIDING CENTER is a therapeutic riding program designed to benefit rider(s) physically, socially and emotionally. Safety Equipment and specially trained horses and volunteers are used. In order to assure the fullest possible protection and greatest personal benefit from the program, each rider is required to furnish the following Medical Information before being accepted as a rider.

NOTE: BECAUSE OF THE NATURE OF THE ACTIVITY OF HORSEBACK RIDING, NO INDIVIDUAL DIAGNOSED WITH DOWN'S SYNDROME CAN BE ACCEPTED FOR RIDING INSTRUCTION WITHOUT PROOF OF A NEGATIVE DIAGNOSTIC X-RAY FOR ATLANTOAXIAL DISLOCATION DISORDER.

DISABILITY/DIAGNOSIS _____ DATE OF ONSET_____

IF DIAGNOSIS IS DOWN'S SYNDROME, THIS FORM MUST BE ACCOMPANIED BY ONE OF THE FOLLOWING:

- SPECIAL OLYMPIC DOWN SYNDROME ATHLETIC EVALUATION
- A SIGNED, DATED STATEMENT FROM A QUALIFIED PHYSICIAN GIVING THE DATE AND RESULT OF A DIAGNOSTIC X-RAY FOR ATLANTOAXIAL DISLOCATION CONDITION.

MEDICAL HISTORY: _____
_____

SURGICAL PROCEDURES: _____
_____

MEDICATIONS: _____ FOR: _____

DEFICITS PRESENT IN:

? SIGHT	? NEURO-SENSATION	? MOBILITY
? HEARING	? MUSCLE TONE	? BRACES IN USE
? SPEECH	? COORDINATION	? ASSISTIVE DEVICES IN USE

COMMENTS ON ABOVE:

_____

COMMENT IF APPLICABLE:

SEIZURES:

_____

INCONTINENCE:

_____

AMBULATION TECHNIQUE_____

GENERAL COMMENTS_____

IN MY OPINION THE PATIENT NAMED CAN RECEIVE RIDING INSTRUCTION UNDER APPROPRIATE SUPERVISION. IN CONJUNCTION WITH THE RIDING PROGRAM, I CONCUR IN THE REFERRAL OF THE PATIENT TO THE STAFF OCCUPATIONAL THERAPIST FOR EVALUATION AND TREATMENT OF HIS/HER PHYSICAL ABILITIES AND/OR LIMITATIONS IN PERFORMING EXERCISES.

PRECAUTIONS OR CONTRAINDICATIONS TO OCCUPATIONAL THERAPY:

_____

_____

PHYSICIAN'S WRITTEN NAME: _____

PHYSICIAN'S NPI NUMBER: _____

_____ _____

PHYSICIAN'S SIGNATURE DATE

_____ _____

ADDRESS PHONE

THIS FORM IS VALID FOR A PERIOD OF ONE (1) YEAR FROM THE DATE SIGNED.

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INFORMATION FOR PHYSICIAN

THE FOLLOWING CONDITIONS, IF PRESENT, MAY REPRESENT PRECAUTIONS OR CONTRAINDICATIONS TO THERAPEUTIC HORSEBACK RIDING. THEREFORE WHEN COMPLETING THIS FORM, PLEASE NOTE WHETHER THESE CONDITIONS ARE PRESENT AND TO WHAT DEGREE.

ORTHOPEDIC

SPINAL FUSION
SPINAL INSTABILITIES
ATLANTOAXIAL INSTABILITIES
SCOLIOSIS
KYPHOSIS
LORDOSIS
HIP SUBLUXATION AND DISLOCATION
OSTEOPOROSIS
PATHOLOGIC FRACTURES
COXAS ARTHROSIS
HETEROTOPIC OSSIFICATION
OSTEOGENESIS IMPERFECTA
CRANIAL DEFECTS
INTERNAL SPINAL STABILIZATION DEVICES

MEDICAL/SURGICAL

ALLERGIES
CANCER
POOR ENDURANCE
RECENT SURGERY
DIABETES
PERIPHERAL VASCULAR DISEASE
VARICOSE VEINS
HEMOPHILIA
HYPERTENSION
SERIOUS HEART CONDITIONS
STROKE (CEREBROVASCULAR ACCIDENT)

NEUROLOGICAL

HYDROCEPHALUS/SHUNT
SPINA BIFIDA
TETHERED CORD
CHIARI 11 MALFORMATION
HYDROMYELIA
PARALYSIS DUE TO SPINAL CORD INJURY
SEIZURE DISORDERS

SECONDARY CONCERNS

BEHAVIOR PROBLEMS
AGE UNDER TWO YEARS
ACUTE EXACERBATION OF CHRONIC DISORDER
INDWELLING CATHETER