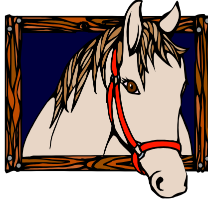
T.H.R.I.L



Therapeutic Horse Riding In Lindsay

Physician Referral Form

Rider Name____ Date of Birth ______________________

Name of Disability____

Primary Diagnosis____

Secondary Diagnosis____

Height ________ Weight _________ (**The maximum weight of any rider must not exceed 180 lbs or 81 kg)**

Diabetic: ◻ Yes ◻ No Insulin: ◻ Yes ◻ No Continence: ◻ Yes ◻ No

Epileptic ◻ Yes ◻ No If yes, indicate type & frequency of seizures________________________________

Date of last seizure____________________ ****Rider/Guardian please complete a Seizure Release Form****

Cerebral Palsy ◻ Yes ◻ No If yes please specify: Monoplegia Diplegia Quadriplegia Hemiplegia (which side L R)

General Health____

Medications____

Atlanto-Axial X-Ray Verification for Riders with **Down Syndrome**

Due to the nature of this activity (horseback riding lessons), Down Syndrome with an atlanto-axial instability is a contraindicated condition. A negative atlanto-axial instability x-ray is required. If the rider has Down Syndrome this form must be signed and dated by a qualified physician giving the date and result of the diagnostic X-ray.

◻ This client does not have Down Syndrome

◻ This client has Down Syndrome Date of X-Ray:________________________

Result of X-Ray:____

Allergies____

Surgery & Dates____

Ambulatory ◻ Yes ◻ No If no, specify (wheelchair, braces, etc.)______________________________________

Communicable Disease ◻ Yes ◻ No If yes, explain____

Physician Referral Form Continued

Tone: Upper extremities____________________ Trunk________________ Lower extremities_______________

Can the patient sit independently? ☐ Yes ☐ No Can they grasp with their hands? ☐ Yes ☐ No

Visual Impairments:____

Balance (Good, Fair, Poor, None): Sitting__________ Standing__________ Walking___________

Language: ☐ English ☐ Other (spoken)______________Sign Language ☐ Yes ☐ No Other____________________

Speech: Good________________ Fair________________ Poor_______________ Non Verbal________________

Ability to understand: ☐ Good ☐ Fair ☐ Poor Comments: _______________________________________

Is there any reason why this person should be precluded from a therapeutic riding program?

____

____

When do you recommend that this form be updated? ☐ Every year ☐ Every two years ☐ Other: _____________

Physician's Signature____ Date_______________________

Physician's Name (please print clearly)____

Address____ City __________________ PC___________

Telephone #____________________________________ Fax #____________________________________

To be completed by the parent/guardian or rider of legal age:
Information Release

I hereby authorize T.H.R.I.L at Field of Dreams Farm to release to its instructors and volunteers such information as may be necessary to conduct a beneficial and safe riding program.

Name of Rider: ____

Date: ____

Signed: ____

Relation to Rider: _____________________________________

Witness: ____

T.H.R.I.L
Visit us at www.thril.ca
Charitable # 76982 4913 RR0001
A non-profit charitable organization located at
Field Of Dreams Farm – Where Dreams Come True!
1072 Monarch Rd, Lindsay, On K9V 4R1 (705) 324 2756 info@thril.ca