T.H.R.I.L.

Therapeutic Horse Riding In Lindsay

Physician Referral Form

Participation in therapeutic horseback riding requires medical clearance to ensure safety. This form must be completed by a licensed physician or nurse practitioner.

Participant Information

- Name: _____
- Date of Birth: ____ / ____ / _____
- Address: _____
- Phone: _____ Email: _____
- Parent/Guardian (if under 18): _____

Medical Information

Diagnosis Primary Diagnosis: _____

Secondary Diagnosis: _____

Physical Information

- Height: _____ cm/in
- Weight: _____ kg/lbs (*Rider weight limit: 180 lbs / 81 kg for mounted activities*)

Medical History

- Surgeries & Dates: _____
- General Health Notes: _____

Conditions (check all that apply):
☐ Diabetes ☐ Insulin dependent ☐ Non-insulin dependent
☐ Epilepsy (type, frequency): _____

- Date of last seizure: _____ (*Seizure Release Form required*)

☐ Cerebral Palsy

- If yes: ☐ Monoplegia ☐ Diplegia ☐ Quadriplegia ☐ Hemiplegia (☐ Left ☐ Right)
  ☐ Communicable Disease (explain): _____
  ☐ Other: _____

Mobility

- Ambulatory: ☐ Yes ☐ No (If no, specify aids: _____)
- Balance: Sitting ☐ Good ☐ Fair ☐ Poor ☐ None
- Standing ☐ Good ☐ Fair ☐ Poor ☐ None
- Walking ☐ Good ☐ Fair ☐ Poor ☐ None

Motor Function

- Tone: Upper Extremities _____ Trunk _____ Lower Extremities _____
- Can patient sit independently? ☐ Yes ☐ No
- Can patient grasp with hands? ☐ Yes ☐ No

Sensory & Communication

- Visual Impairments: _____
- Speech: ☐ Good ☐ Fair ☐ Poor ☐ Non-verbal
- Language: ☐ English ☐ Other _____ ☐ Sign Language
- Comprehension: ☐ Good ☐ Fair ☐ Poor
- Comments: _____

Medications: _____
Allergies (medications, environmental, animals): _____

Down Syndrome / Atlanto-Axial Instability

If patient has Down Syndrome, an x-ray verifying absence of atlantoaxial instability is required.

☐ This client does not have Down Syndrome
☐ This client has Down Syndrome

- Date of X-ray: _____
- Result: _____

Physician Declaration

In my medical opinion, this individual is:
☐ Medically able to participate in therapeutic horseback riding with supervision
☐ Not medically able to participate at this time

Recommended form update:
☐ Every year ☐ Every two years ☐ Other: _____

Precautions/Recommendations: _____

Physician Name: _____
Clinic/Practice: _____
Phone: _____ Fax: _____
Signature: _____ Date: ____ / ____ / _____

Participant / Guardian Authorization

I authorize T.H.R.I.L. to share relevant medical information with instructors and volunteers for the purpose of ensuring a safe and beneficial program.

Participant Name: _____
Signature: _____ Date: ____ / ____ / _____
Parent/Guardian (if applicable): _____
Witness: _____

T.H.R.I.L
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