

## Physician's Referral Form

Patient's Name: \_\_\_\_\_ Age \_\_\_\_\_  
Parent's/Guardian's Name \_\_\_\_\_  
Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_  
Date of Birth \_\_\_\_\_ Height \_\_\_\_\_ Weight \_\_\_\_\_

### MEDICAL HISTORY

Diagnosis \_\_\_\_\_ Date of Onset \_\_\_\_\_

Primary Problem \_\_\_\_\_  
Secondary Problem \_\_\_\_\_  
Other \_\_\_\_\_  
Hospitalizations/Reasons \_\_\_\_\_

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Surgical Procedures/Dates \_\_\_\_\_

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Shunts \_\_\_\_\_ Implants \_\_\_\_\_  
Appliances \_\_\_\_\_ Assistive devices \_\_\_\_\_  
Seizures \_\_\_\_\_ Medications \_\_\_\_\_  
Psychological (I.Q. if pertinent) \_\_\_\_\_  
Professionals/Agencies Involved \_\_\_\_\_

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### PHYSICAL

Skin/Circulation \_\_\_\_\_ Neuro/Sensation \_\_\_\_\_  
Heart/Lungs \_\_\_\_\_ Balance/Coordination \_\_\_\_\_  
Bowel \_\_\_\_\_ Bladder \_\_\_\_\_  
Vision \_\_\_\_\_ Hearing \_\_\_\_\_  
Speech \_\_\_\_\_ Spasticity/Rigidity \_\_\_\_\_  
Other \_\_\_\_\_

Precautions/Contraindications to Therapeutic Horseback Riding \_\_\_\_\_

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### OTHER INFORMATION

What behaviors should be encouraged/discouraged? \_\_\_\_\_

Can the client read? \_\_\_\_\_ If yes, at what level? \_\_\_\_\_

Please list any other information that would help **Body & Spirit** better serve the individual. \_\_\_\_\_

In my opinion, this patient is able to receive riding instruction under appropriate supervision. In conjunction with **Body & Spirit Therapeutic Riding and Hippotherapy Program**, I concur in the referral of this patient to a Physical Therapist for evaluation of his/her abilities and limitations with regard to horseback riding.

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Physician's Signature \_\_\_\_\_ Date \_\_\_\_\_

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Physician's Name (Print) \_\_\_\_\_ Phone \_\_\_\_\_

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Office address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

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Parent/Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_

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Parent/Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_