Information for Physician

Date: ___________________

Dear Health Care Provider:

Your patient, ____
(participant's name)

is interested in participating in supervised equine activities. In order to safely provide this service, our center requests that you complete/ update the following Medical Historyand Physician's Statement Form. Please note that the following conditions, if present, may represent precautions and/or contraindications to equine assisted activities. Therefore, when completing this form,
contraindications to equine assisted activities. Therefore, when completing this form,

Orthopedic

Atlantoaxial Instability- include neurologic signs
Coxarthrosis
Cranial Defects
Heterotropic Ossification/ Myositis
Ossificans Joint subluxation/ dislocation
Osteoporosis
Pathologic fractures
Spinal joint fusion/ fixation
Spinal joint instability/ abnormalities

Neurologic

Hydrocephalus/ shunt
Seizure
Spina Bifida/ chiari II malformation/ tethered cord/ hydromyelia

Other

Age- under 5 years
Indwelling catheters/ medical equipment
Medications- photosensitivity
Poor endurance
Skin breakdown

Medical/Psychological

Allergies
Animal abuse
Cardiac conditions
Physical/ sexual/ emotional abuse
Blood pressure control
Dangerous to self or others
Exacerbations of medical conditions (RA, MA)
Fire setting
Hemophilia
Medical Instability
Migraines
PVD
Respiratory compromise
Recent Surgeries
Substance Abuse
Thought control disorders
Weight control disorder

I hereby authorize ____ (person or facility) to release information from the records of ___________________________________ DOB:________________
(name of participant)

The information is to be released to: Whispering Manes Therapeutic Riding Center and/or its agents, for the purpose of developing an equine assisted activity program for the above named participant.

This release is valid and can be revoked, in writing, at my request.

Signature:____ Date: _________________________
Print Name:____

Thank you very much for you assistance. If you have any questions or concerns regarding this patient's participation in equine assisted activities, please feel free to contact a staff member at the address or phone number provided below.

6105 SW 125th Ave, Miami, FL 33183 | 305-596-4204 | www.whisperingmanes.org

PHYSICIAN'S STATEMENT

Please complete this form in its entirety or it will be returned to you.
Enrollment cannot be finalized without a current signed statement on file.

Participant: ___________________________ DOB: _________Height: _____" Weight:______lbs

Address:____
City:__________________________ State:___________ Zipcode:________________________

Diagnosis: ____ Date of Onset:________________
Medications:____

Seizure Type: _____________________Controlled: Y N Last Seizure Date:____________

Shunt Present:Y N Last Revision Date:_________ Tetanus Shot: Y N Date:_________
Special Precautions/ Needs: ____
____
____

Mobility: Independent Ambulation Y N Assisted Ambulation Y N Wheelchair Y N

Braces/ Assistive Devices: ____

For those with Down Syndrome:
AtlantoDens Interval Radiographs Date: _______________________ Result: Neg Pos
Negative for Neurological Symptoms of Atlanto Axial Instability: Y N

Indicate if patient has a problem and/or any past or prospective surgeries in any of the following areas. If checked please comment

Allergies_____________________________ Auditory/Speech____________________________
Behavioral/Emotional___________________ Balance__________________________________
Cardiovascular________________________ Gastrointestinal____________________________
Genitourinary_________________________ Immunological_____________________________
Integumentary________________________ Muscular_________________________________
Neurological__________________________ Orthopedic_______________________________
Pain________________________________ Psychological_____________________________
Tactile_______________________________ Thinking/Cognition_________________________
Visual_______________________________ Other___________________________________

Given the above diagnosis and medical information, this person is **not** medically precluded from participation in equine assisted activities and/ or therapies. I understand that Whispering Manes Therapeutic Riding Center will weigh the medical information given against the existing precautions and contraindications. Therefore, I refer this person to the Whispering Manes Therapeutic Riding Center for ongoing evaluation to determine eligibility for participation.

Name: ____ MD DO NP PA Other: _____________
Signature: ____ Date: ______________________
Address: ____
____
Phone:____________________________________ License/UPIN:______________________________