Health Directed Riding, Inc
Where Rehab Reins

Date: _____

Dear Physician,

Your patient, _____ is interested in participating in supervised equestrian activities.
In order to safely provide this service, our riding program requests that you complete the attached Medical History and Physician's Statement Form. Please note that the following conditions may suggest precautions and contraindications to therapeutic horseback riding. Therefore, when completing this form, please note whether these conditions are present and to what degree.

Orthopedic
Atlantoaxial Instability – Include neurologic symptoms
Coxa Arthrosis
Cranial Deficits
Heterotopic Ossifications / Myositis Ossificans
Joint subluxation / dislocation
Osteoporosis
Pathologic Fractures
Spinal Fusion / Fixation
Spinal instability / Abnormalities

Neurologic
Hydrocephalus / Shunt
Seizure
Spina Bifida / Chiari II
Malformation / tethered cord/Hydormyelia

Medical/Psychological
Allergies
Animal Abuse
Physical/Sexual/Emotional abuse
Blood Pressure Control
Dangerous to self or others
Exacerbations of medical condtion
Fire settings
Heart Condition
Hemophilia
Medical Instability
Migraines
PVD
Respiratory compromise
Recent surgeries
Substance abuse
Thought control disorders
Weight control disorder

Other
Age – under 4 years
Indwelling catheters
Medications – ie. Photosensitivity
Poor endurance
Skin breakdown

Thank you very much for your assistance. If you have any questions or concerns regarding this patient's participation in therapeutic equine activities please feel free to contact the center at the address / phone indicated above.
Sincerely,