Little Bit Therapeutic Riding Center Dunmire Stables

18675 NE 106th Street, Redmond WA 98052
Phone: 425-882-1554 Fax: 425-883-1818
littlebit.org

Information for Physician

The following conditions, if present, may represent **PRECAUTIONS** or **CONTRAINDICATIONS** to therapeutic horseback riding. Therefore, when completing this form, please note whether these conditions are present, and to what degree.

Medical/Surgical

Allergies to Grasses, Animals and Dust
Cancer
Diabetes
Hemophilia
Hypertension
Peripheral Vascular Disease
Poor Endurance
Recent Surgery
Serious Heart Condition
Stroke (Cerebrovascular Accident)
Varicose Veins

Orthopedic

Atlantoaxial Instabilities
Coxarthrosis
Cranial Deficits
Heterotopic Ossification
Hip Subluxation and Dislocation
Internal Spinal Stabilization Devices
(such as Harrington Rods)
Kyphosis
Lordosis
Osteogenesis Imperfecta
Osteoporosis
Pathologic Fractures
Osteogenesis Imperfecta
Scoliosis
Spinal Fusion
Spinal Instabilities/Abnormalities
Spinal Orthoses

Neurological

Chiari II Malformation
Hydrocephalus/shunt
Hydromyelia
Paralysis due to Spinal Cord Injury (above T-9)
Spina Bifida
Tethered Cord
Uncontrolled Seizure Disorders

Secondary Concerns

Acute exacerbation of chronic disorder
Behavior Problems
Indwelling catheter
Weight limit 190 lbs.

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Date:_____

MEDICAL HISTORY

(Please be sure to fill out every area)

Name:_____ D.O.B. ____/____/____ Age:_____

Address:_____ Phone:_____

Weight (lbs): _____ Height:_____ Sex:_____ Pulse:_____ B.P._____

Diagnosis:_____ICD-10:_____

Cause: _____

Secondary Diagnosis(s) (if applicable): _____

Cause:_____

Medications (Type, Purpose, Dose):_____

_____

_____

If Down Syndrome:
Complete Neurological Exam showing no evidence of Atlanto-Axial Subluxation:
Positive: _____ Negative: _____Date:_____

_____

Please indicate if the client had or has a history of the following secondary problems by checking yes or no. If **YES**, please include **COMPLETE** information pertaining to the problem.

YES	NO	CONDITION
□	□	Spinal Fusion – if yes, which vertebrae_____
□	□	Spinal Instability/Abnormalities – if yes, which vertebrae_____
□	□	Scoliosis – if yes, explain_____
□	□	Kyphosis (Excessive or Abnormal)
□	□	Lordosis (Excessive or Abnormal)
□	□	Hip Subluxation and/or Dislocation – if yes, describe_____
□	□	Osteoporosis
□	□	Pathologic Fractures
□	□	Arthritis – Type_____
□	□	Coxarthrosis
□	□	Heterotopic Ossification
□	□	Osteogenesis Imperfecta
□	□	Spinal Orthoses
□	□	Internal Spinal Stabilization Devices – Type_____
□	□	Hydrocephalus with Shunt – Location of Shunt_____
□	□	Spina Bifida – Type and Level_____

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YES	NO	CONDITION
□	□	Tethered Cord
□	□	Chiari II Malformation
□	□	Hydromyelia
□	□	Paralysis
□	□	Cranial Deficits
□	□	Cerebral Palsy – Type_____
□	□	Gastrostomy Tube – Type_____
□	□	Atlantoaxial Instabilities_____
□	□	Seizures – Type_____Date of last Tonic/Clonic (Grand Mal) Seizure_____
□	□	Controlled with medication – if yes, list_____
		Last date adjusted_____
□	□	Allergies – Type_____
□	□	Diabetes – Type_____
□	□	Peripheral Vascular Disease – Type_____
□	□	Varicose Veins
□	□	Poor Endurance
□	□	Hemophilia
□	□	Hypertension
□	□	Controlled with medication – if yes, list_____
□	□	Heart Condition – Type_____
□	□	Cerebrovascular Accident (Stroke) – Date_____
□	□	Cancer – Type_____
□	□	Aneurysm
□	□	Known embolus – Location_____
□	□	Known thrombus – Location_____
□	□	Current Tetanus Shot – Date_____

Cognitive IQ:_____ Known Behavior Problems:_____

_____

Incontinence_____ Postural Muscle Tone_____
Visual Concerns_____ Auditory Concerns_____
Speech Concerns_____ Circulation_____
Neuro-Sensation_____ Coordination_____
Spasticity and/or Rigidity_____
Braces_____
Assistive Devices (i.e. wheelchair, crutches, etc)_____

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General Comments_____

_____

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_____

Given the above diagnosis and medical information, this person is not medically precluded from participation in Equine Assisted Activities. I understand that the PATH center will weigh the medical information given against the existing precautions and contraindications. Therefore, I refer this person to the PATH center for ongoing evaluation to determine eligibility for participation.

Physician's Signature:_____ Date:_____

Address:_____ City:_____ Zip:_____

Phone:_____ Physician's Name (please print)_____

Fax:_____

MEDICAL FORMS MUST BE DATED AND SIGNED BY PHYSICIAN

Please return this form to: Little Bit Therapeutic Riding Center Dunmire Stables
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