



Therapeutic Riding Equestrian Center
8342 Platz Road
Fairview, PA 16415
PH 814.474.5276
Fax 814.474.5070
www.trecenter.org

Dear Physician,

Please note that the following conditions may suggest precautions and contraindications to therapeutic horseback riding.

Therefore, when completing the referral form, please note whether these conditions are present, and to what degree.

Orthopedic

Atlantoaxial Instability - include neurologic symptoms
Coxa Arthrosis
Cranial Deficits
Heterotopic Ossification/Myositis Ossificans
Joint subluxation/dislocation
Osteoporosis
Pathologic Fractures
Spinal Joint Fusion/Fixation
Spinal Joint Instability/Abnormalities

Neurologic

Hydrocephalus/Shunt
Sensory Deficit
Seizure
Spina Bifida/Chiari II malformation/Tethered Cord/Hydromyelia

Other

Age - under 4 years
Indwelling Catheters/Medical Equipment
Medications - i.e. photosensitivity
Poor Endurance
Skin Breakdown

Medical/Psychological

Allergies
Animal Abuse
Cardiac Condition
Physical/Sexual/Emotional Abuse
Blood Pressure Control
Dangerous to self or others
Exacerbations of medical conditions (i.e. RA, MS)
Fire Settings
Hemophilia
Medical Instability
Migraines
PVD

Weight Control Disorder
Thought Control Disorders
Substance Abuse
Recent Surgeries
Respiratory Compromise



**Therapeutic Riding Equestrian Center
Physician's Referral**

**Please complete and return
as soon as possible to:
TREC Program Director
8342 Platz Rd. Fairview, PA 16415
Ph 814.474.5276
Fax 814.474.5070**

Please Print or Type

Participant _____ Date of Birth _____

Address _____ City _____ Zip _____

Physically Handicapped: yes ____ no ____ Mentally Retarded: yes ____ no ____

Emotionally Disturbed: yes ____ no ____ Learning Disabled: yes ____ no ____

Diagnosis: _____

Cause: _____ Onset: _____

Limbs Affected: _____

If spinal cord involvement, what vertebral level? _____

If Down's Syndrome*, are signs and symptoms of Atlantoaxial Dislocation (ADC) present as determined by an x-ray? ____ Yes, signs of ADC are present ____ No; signs of ADC are not present

Date of last X-ray _____

*If the patient has Downs Syndrome, please x-ray for ADC or signs and symptoms thereof. ADC is a dislocation of the joints between two cervical vertebrae, which could result in paralysis. If signs or symptoms of ADC are present, DO NOT refer the patient to TREC for therapeutic riding.

Height _____ Weight _____

Current Medications: Please list any medications the patient currently takes on a regular basis:

Please indicate if the applicant has any of the following secondary problems by checking yes or no. If yes, please include complete information pertaining to the problem.

PROBLEM	YES	NO	If yes, please describe:
Visual			
Hearing			
Sensation			
Communication			
Emotional/Mental Health			
Behavioral			
Thinking/Cognition			
Allergies			
Cardiac			Pulse: Blood Pressure:

<u>PROBLEM</u>	<u>YES</u>	<u>NO</u>	<u>DESCRIPTION</u>
Circulatory Peripheral Vascular Dis.			
Pulmonary			
Metabolic/G.I. G.U. Diabetes			
Skin and Soft Tissue Pressure sore			Healed (yes no) Location
Neurological Seizures			Type Controlled (yes no) Last seizure
Hydrocephalus			Shunt (yes no)
Sensory Loss			
Surgery			
Muscular			
Pain			
Skeletal			
Subluxing Hips			
Dislocating Hips			
Subluxing Shoulders			
Dislocating Shoulders			
Spinal Laminectomy			
Osteoporosis			
Heterotrophic Ossific			
Spondylosis			
Spondylolisthesis			
Scoliosis			Degree, Type
Fractures			Location, healed?
Other			

In my opinion, this patient can receive supervised riding instruction.

Precautions or contraindications:

Physician's Signature _____ Date: _____

Physician Name: _____ MD DO NP PA Other _____

Address: _____ City _____ State _____ Zip Code _____

Phone: _____