3100 McCormick Rd. Harrow, ON N0R 1G0 519-322-8365

Physician Referral Form

Name: ____________________________________ Date of birth: ____________________

Address: ____

Phone: home: ________________ work: __________________other: ________________

Next of Kin/Guardian: ____

Living at home: ____________ Other: ____

Medical

Primary Diagnosis: ____

Secondary Diagnosis: ____

Height: __________________Weight: __________________ Sex: ___________________

Diabetic: ________________Insulin: ____________________Epileptic: ______________

If epileptic, frequency of seizures: ________________ Date of last seizure: ____________

Medications: ____

For: ____

Communicable disease: Yes________ No________ If yes explain: __________________

____

Surgery Date:

____ __________________________

____ __________________________

Ambulatory: Yes________ No________ If yes, specify:_____________________________

Muscle Tone (spasticity, flaccidity, etc.)

Tone in upper extremities: ____

Tone in lower extremities: ____

Tone in trunk: ____

Balance sitting: _____________Standing _______________Walking ______________

Language: English: __________Sign Language: ___________Other: ______________

Speech: Good: ___________ Fair: ___________ Poor: ___________

Ability to understand: Good: ___________ Fair: ____________ Poor: ___________

Sensory Function: Sight: ___________ Hearing: ____________ Tactile: ___________

Continence: _________________

Allergies: ____

____

I hereby give my permission for the above individual to participate in the riding program named SpEqTRA.

Physician's signature: ________________________________Date: _______________

Physician's name: ____
(please print clearly)

Physician's address: ____

Telephone: _____________________________ Fax: ___________________________

*Note: It is important that this form be filled out in detail (e.g. height, weight, etc.) in order for the instructor to match the rider with the mount.