Special Equestrians
Therapeutic Riding Association

528 Mersea Rd. 7 R.R.#5 Leamington, Ontario N8H 3V8 (519)322-2463

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 at Windsor Farms Equine Centre.

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 and physiotherapist to match the rider with the mount.