PATH INTERNATIONAL
Professional Association of Therapeutic Horsemanship International

LifeStriders
Therapeutic Riding Center

S11 W29667 Summit
Avenue (US HWY 18)
Waukesha, WI 53188

Phone: (262) 565-6124
Email: striders@lifestriders.org
www.lifestriders.org
Fax: 866.404.3105

Participant's Medical History & Physician's Statement

(Must Be Signed by Pediatrician or Treating Medical Specialist)

Participant: _____ DOB: _____ Height: _____ Weight: _____

Address: _____

Diagnosis: _____ Date of Onset: _____

Past/Prospective Surgeries: _____

Medications: _____

Seizure Type: _____ Controlled: ☐ Y ☐ N Date of Last Seizure: _____

Shunt Present: ☐ Y ☐ N Date of last revision: _____

Special Precautions/Needs: _____

Mobility: Independent Ambulation ☐ Y ☐ N Assisted Ambulation ☐ Y ☐ N Wheelchair ☐ Y ☐ N

Braces/Assistive Devices: _____

For those with Down Syndrome: AtlantoDens Interval X-rays, date: _____ Result + -

Neurologic Symptoms of AtlantoAxial Instability: _____

Please indicate current or past difficulties in the following systems/areas, including surgeries:

	Y	N	Comments
Auditory			
Visual			
Tactile Sensation			
Speech			
Cardiac			
Circulatory			
Integumentary/Skin			
Immunity			
Pulmonary			
Neurologic			
Muscular			
Balance			
Orthopedic			
Allergies			
Learning Disability			
Cognitive			
Emotional/Psychological			
Pain			
Other			

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Physician's Order for Occupational Therapy/Individual Counseling/Group Therapy
(Must Be Signed by Pediatrician or Treating Medical Specialist)

Participant:_____ has been deemed eligible for:

_____Occupational therapy services based on evaluation

_____Individual Counseling and/or Group Therapy services based on evaluation

Participants Name: _____ Birthdate: _____

Parent/Guardian _____

Address: _____ Phone: _____

Physician: Please complete the items below. The form may be returned to your client, or to LifeStriders via fax or email. If clinics own prescription form is required, please be sure to include it in the returned packet. Thank you!

_____ Please provide Occupational Therapy services as needed
_____Please provide Individual Counseling/Group Therapy services as needed

Medical Diagnosis/Description of Disability:_____
_____

Precautions/Contraindications:_____
_____

Additional Comments:_____
_____

This referral form will be valid for **1 year**, unless services are terminated, there is a change in the above mentioned participants medical status, or an updated order is necessary.

Physician's Name: _____

Phone: _____

Address: _____

Physician's Signature: _____ Date: _____

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Physician's Statement

(Must Be Signed by Physician or Treating Medical Specialist)

To my knowledge, there is no reason why this person cannot participate in supervised equestrian activities. However, I understand that the therapeutic riding center will weigh the medical information above against the existing precautions and contraindications. I concur with a review of this person's abilities/limitations by a licensed/credentialed health professional (e.g. PT, OT, Speech, Psychologist, etc.) in the implementation of an effective equestrian program.

Name of Participant: _____

Name/Title: _____ ☐ MD ☐ DO ☐ NP ☐ PA ☐ Other: _____
Signature: _____ Date: _____
Address: _____
Phone: ( ) _____ License/UPIN Number: _____
Email: _____