6920 Concession 1, R.R. #2, Puslinch, ON N0B 2J0 ● 519-37-0558 ● 519-837-1233
www.sunrise-therapeutic.ca ● info@sunrise-therapeutic.ca

Dear Physician,

One of your patients has contacted our organization expressing an interest in joining our Therapeutic Riding/ Camp Program.

Enclosed is a Physician Referral Form and a list of contraindications and precautions for Therapeutic Riding. If your patient also has issues concerning their mental health, please also complete the Mental Health Addendum.

Please review **the list of contraindications and precautions**, and consider the ones that may be applicable for your patient. As well, please review the list of conditions that require cervical spine and/or flexion-extension X-Ray. If an X-Ray is indicated, please attach a copy of the results of the X-Ray report to this referral. Where possible, please be specific with your comments. Your comments will help our therapists and instructors decide on this patient's suitability for riding and help them provide a better quality individualized program for the patient.

To ensure we are using accurate information, if the form is filled out by any person other than the physician it will be returned to the applicant. Some portions may be completed by a physiotherapist or occupational therapist in addition to the physician.

Horseback riding is considered a risk sport; therefore the highest standards of safety and therapeutic riding instruction, as per the Canadian Therapeutic Riding Association, are maintained.

Please feel free to contact me with any questions. Thank you for your cooperation!

Sincerely,

Camilla Giffen

Camilla Giffen, E.C. Coach 2
Head Instructor
519-837-0558 x29
camillla@sunrise-therapeutic.ca

Guidelines for Physicians/ Therapists
CONTRAINDICATIONS AND PRECAUTIONS
FOR THERAPEUTIC RIDING

The following conditions may represent precautions or contraindications to therapeutic horseback riding if present in potential participants. Therefore, when completing the physician's referral, please note whether these conditions are present and to what degree.

ABSOLUTE CONTRAINDICATIONS

ORTHOPAEDIC
- Acute arthritis
- Acute herniated disc or prolapsed disc
- Atlanto-axial instabilities
- Coax arthrosis (degeneration of hip joint)
- Structural cranial deficits
- Osteogenesis imperfecta
- Pathological fractures
- Spondylolisthesis
- Structural scoliosis >30 degrees, excessive kyphosis or lordosis or hemivertebra
- Spinal stenosis
- Hip subluxation, dislocation or dysplasia (one hip)

NEUROLOGICAL
- CVA secondary to unclipped aneurysm or angioma
- Paralysis due to spinal cord injury above T6 (adult)
- Spina bifida associations – Chiari II malformations, hydromyelia, tethered cord
- Uncontrolled seizures within the last 6 months

MEDICAL
- Obesity or >170 lbs

RELATIVE CONTRAINDICATIONS AND PRECAUTIONS

OTHER
- Age under 2 years old
- Any condition that the instructor, therapist, physician or program does not feel comfortable accepting into the program

ORTHOPAEDIC
- Arthrogryposis
- Heterotopic ossification
- Hip subluxation, dislocation or dysplasia
- Osteoporosis
- Spinal fusion/fixation, Harrington Rod (within 2 years of surgery)
- Spinal instabilities/abnormalities
- Spinal orthoses

NEUROLOGICAL

- Amyotrophic Lateral Sclerosis
- Fibromyalgia
- Gullian Barre Syndrome
- Exacerbation of Multiple Sclerosis
- Post Polio Syndrome
- Hydrocephalic shunt

MEDICAL / PSYCHOSOCIAL

- Abusive or disruptive behaviour
- Cancer
- Hemophilia
- History of skin breakdown or skin grafts
- Abnormal fatigue
- Incontinence (must wear protection)
- Peripheral vascular disease
- Sensory deficits
- Serious heart condition or hypertension
- Significant allergies
- Surgery within the last three months
- Uncontrolled diabetes
- Indwelling catheter
- Substance abuse
- Anticoagulants (bleeding risk)

FLEXION/EXTENSION X-RAY REQUIRED FOR ATRAUMATIC FACTORS THAT MAY BE ASSOCIATED WITH AN UNSTABLE UPPER CERVICAL SPINE

- Down syndrome
- Os odontoideum
- Athetoid cerebral palsy
- Rheumatoid arthritis of cervical vertebrae
- Congenital torticollis
- Sprengel's deformity
- Ankylosing spondylitis
- Congenital atlanto-occipital instability
- Klippel-Feil syndrome
- Chiari malformation with condylar hyperplasia
- Fusion of C2-C3
- Lateral mass degeneration change at C1-C2
- Systemic lupus
- Morquio disease
- Non-rheumatoid cranial settling
- Subluxation of upper cervical vertebrae due to tumours or infection
- Idiopathic laxity of the ligaments
- Grisel’s syndrome
- Lesch-Nyhan syndrome
- Marshall-Smith syndrome
- Diffuse idiopathic hyperostosis
- Congenital chondrodysplasia

Sunrise Therapeutic Riding and Learning Centre

Physician Referral Form

NAME OF INDIVIDUAL		**PHONE**	
ADDRESS		**CITY/POSTAL CODE**	
AGE	**DATE OF BIRTH**	**HEIGHT**	**WEIGHT**

PATIENT'S PARENT / GUARDIAN CONTACT	**PHONE (H)**	**PHONE (W)**
EMAIL		

PRIMARY DIAGNOSIS	**DATE OF ONSET**
SECONDARY DIAGNOSIS	**DATE OF ONSET**

PLEASE BE SPECIFIC WHEN COMMENTING ON IMPAIRMENTS		**If Atypical, comments**
AUDITORY IMPAIRMENTS	**YES NO**	
SPEECH IMPAIRMENTS	**YES NO**	
ORAL MOTOR FUNCTION	**Normal Atypical**	
VISUAL IMPAIRMENTS	**YES NO**	
BEHAVIOURAL OR PSYCHOLOGICAL CONCERNS	**YES NO**	
CIRCULATORY IMPAIRMENTS	**YES NO**	
NORMAL SENSATION	**YES NO**	
INCONTINENCE	**BLADDER NO**	**YES**
	BOWEL NO	**YES**
SEIZURE DISORDER	**TYPE:** **DATE OF LAST SEIZURE:**	**MEDS:**
DIABETIC	**TYPE I**	**TYPE II**
HIP SUBLUXATION OR DISLOCATION	**LEFT** **RIGHT**	**BOTH**

****Please refer to Contraindications and Precautions****

THIS SECTION TO BE COMPLETED BY PHYSICIAN AND/OR PHYSIOTHERAPIST, AS APPROPRIATE

GROSS MOTOR SKILLS:	**GOOD**	**FAIR**	**POOR**	**COMMENTS**
FINE MOTOR SKILLS:	**GOOD**	**FAIR**	**POOR**	**COMMENTS**
BALANCE (SITTING):	**GOOD**	**FAIR**	**POOR**	**COMMENTS**
BALANCE (STANDING):	**GOOD**	**FAIR**	**POOR**	**COMMENTS**
MUSCLE TONE:	**HIGH**	**LOW**	**NORMAL**	**COMMENTS**

MEDICATIONS: *(PLEASE SPECIFY)* *Attach separate sheet as necessary or preferred*	
RELEVANT MEDICATION SIDE EFFECTS: **(ex. Aggression, lethargy, dizziness, bleeding risk etc)** *(PLEASE SPECIFY)*	
RELEVANT SURGERIES AND DATES (Spinal Rods/Fusion)	
ASSISTIVE DEVICES, BRACE, BOTOX DATES *(PLEASE SPECIFY)*	
SHUNTS	**NO** **YES** **Comment:**
COMMUNICABLE DISEASES	**NO** **YES** **Comment:**
ALLERGIES: *(PLEASE SPECIFY)*	**EPINEPHRINE AUTOINJECTOR:** **YES** **NO**
DATE OF LAST TETANUS:	
IMMUNIZATIONS UP TO DATE:	
SPECIAL DIET:	
DOWN SYNDROME & RHEUMATOID CERVICAL SPINE X-RAYS **(see contraindications)** ****Must be within 5 years and redone every 5 years until adulthood****	**YEAR & DETAILS (attach report)**

COMMENTS

HOW OFTEN SHOULD THIS FORM BE UPDATED?	YEARLY	EVERY 2 YEARS	EVERY 5 YEARS	Not Necessary

In my opinion, this patient can receive therapeutic riding under proper instruction. I understand that this patient may receive assessment by a physical therapist, occupational therapist, or other licenced professional, in conjunction with this riding program regarding his/her physical abilities and/or limitations in performing exercises and activities on the horse.

PHYSICIAN'S NAME	PHONE
ADDRESS	CITY/POSTAL CODE
SIGNATURE	DATE

PHYSIOTHERAPIST'S NAME (If applicable)	PHONE
ADDRESS	CITY/POSTAL CODE
SIGNATURE	DATE

Sunrise respects your privacy and will not transfer your personal health information via unsecured email. Sunrise protects your personal information and adheres to all legislative requirements with respect to protecting privacy. We do not rent, sell or trade our mailing lists. The information you provide will be used to deliver services and to keep you informed and up to date on the activities of Sunrise, including programs, services, special events, funding needs, and volunteer opportunities throughout periodic contacts. If at any time you wish to be removed from our mailing list simply contact us by phone at 519-837-0558 or via email at info@sunrise-therapeutic.ca