



North Fraser Therapeutic Riding Association

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PHYSICIAN'S REFERRAL FORM

(Please print clearly)

Name of Rider: _____ Date of Birth and Age: _____

Weight (in pounds): _____ **Height (feet/inches):** _____
Please weight rider:

Diagnosis/Disability: _____

Date of Onset: _____

How often should this form be updated/date? _____
Please indicate when

IMPAIRMENTS	YES/NO ABNORMAL/NORMAL		COMMENTS
Auditory Impairments			
Speech Impairments			
Visual Impairments			
Circulatory Impairments			
Sensation			
Incontinence - Bladder			
Incontinence – Bowel			
Assistive Devices			
Psychological or Behavior Concerns			
Spinal/Joint Abnormalities			
Spinal Support rods (i.e. Herrington or other)			
Scoliosis Degree			
Hip Subluxation or Dislocation			
Co-ordination in lower			
Extremities:			
Muscle Tone – Arms:			
Muscle Tone – Legs:			
Muscle Tone – Trunk/Legs			
Balance – static sitting			
Balance – dynamic sitting			
Seizures (grand/petit/date)			
Medication/s – please list			
Medication/s Side Effects			
Relevant Surgeries/Dates			

IMPAIRMENTS	YES/NO ABNORMAL/NORMAL		COMMENTS
Tetanus Vaccine/Date			
Allergies			
Downs Syndrome & Rheumatoid Cervical Spine X-Rays (Sub-occipital & Atlanto/Axial Joints (Year)			
Flexion/Extension X-Rays Required/Year			
<i>When applicable, please include a copy of cervical spine or flexion/extension X-ray report</i>			
Precautions (if yes – please indicate): _____ _____ _____ _____ _____ _____ _____ _____			
Comments: _____ _____ _____ _____ _____ _____ _____ _____ _____			
<i>In my opinion, this patient can receive riding lessons under proper instruction. I understand that this patient may receive assessment/treatment by a volunteer physiotherapist, occupational therapist or psychologist in conjunction with this riding program regarding his/her physical and/or behavioral abilities/limitation/s in performing with the program.</i>			
Signature Date: _____			
Physician's Stamp: 			