

# WindReach Farm

A centre for inclusion and personal achievement for people of all abilities.

[www.windreachfarm.org](http://www.windreachfarm.org)

## Physician Referral Form 2017

Rider Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

Address \_\_\_\_\_ Postal Code \_\_\_\_\_

Phone Number \_\_\_\_\_ Email Address \_\_\_\_\_

Name of Disability \_\_\_\_\_

Primary Diagnosis \_\_\_\_\_

Secondary Diagnosis \_\_\_\_\_

Height \_\_\_\_\_ Weight \_\_\_\_\_ ( The maximum weight of any rider must not exceed 180 lbs or 81 kg )

Diabetic:  Yes  No Insulin:  Yes  No Continence:  Yes  No

Epileptic  Yes  No If yes, indicate type & frequency of seizures \_\_\_\_\_

Date of last seizure \_\_\_\_\_ **\*\*Rider/Guardian please complete a Seizure Release Form\*\***

Cerebral Palsy  Yes  No If yes please specify: Monoplegia Diplegia Quadriplegia Hemiplegia (which side L R)

General Health \_\_\_\_\_

Medications \_\_\_\_\_

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### Atlanto-Axial X-Ray Verification for Riders with Down Syndrome

Due to the nature of this activity (horseback riding lessons), Down Syndrome with an atlanto-axial instability is a contraindicated condition. A negative atlanto-axial instability x-ray is required. If the rider has Down Syndrome this form must be signed and dated by a qualified physician giving the date and result of the diagnostic X-ray.

This client does not have Down Syndrome

This client has Down Syndrome Date of X-Ray: \_\_\_\_\_

Result of X-Ray: \_\_\_\_\_

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Allergies \_\_\_\_\_

Surgery & Dates \_\_\_\_\_

Ambulatory  Yes  No If no, specify (wheelchair, braces, etc.) \_\_\_\_\_

Communicable Disease  Yes  No If yes, explain \_\_\_\_\_

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Please continue on reverse of page...

## Physician Referral Form Continued

Tone: Upper extremities \_\_\_\_\_ Trunk \_\_\_\_\_ Lower extremities \_\_\_\_\_

Can the patient sit independently?  Yes  No Can they grasp with their hands?  Yes  No

Visual Impairments: \_\_\_\_\_

Balance (Good, Fair, Poor, None): Sitting \_\_\_\_\_ Standing \_\_\_\_\_ Walking \_\_\_\_\_

Language:  English  Other (spoken) \_\_\_\_\_ Sign Language  Yes  No Other \_\_\_\_\_

Speech: Good \_\_\_\_\_ Fair \_\_\_\_\_ Poor \_\_\_\_\_ Non Verbal \_\_\_\_\_

Ability to understand:  Good  Fair  Poor Comments: \_\_\_\_\_

Is there any reason why this person should be precluded from a therapeutic riding program?

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

When do you recommend that this form be updated?  Every year  Every two years  Other: \_\_\_\_\_

Physician's Signature \_\_\_\_\_ Date \_\_\_\_\_

Physician's Name (please print clearly) \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ PC \_\_\_\_\_

Telephone # \_\_\_\_\_ Fax # \_\_\_\_\_

### To be completed by the parent/guardian or rider of legal age:

#### Information Release

I hereby authorize The Stables at WindReach Farm to release to its instructors and volunteers such information as may be necessary to conduct a beneficial and safe riding program.

Name of Rider: \_\_\_\_\_

Date: \_\_\_\_\_

Signed: \_\_\_\_\_

Relation to Rider: \_\_\_\_\_

Witness: \_\_\_\_\_