WindReach Farm

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

Physician Referral Form 2018

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_____

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:_____

Allergies_____

Surgery & Dates_____

Ambulatory ☐ Yes ☐ No If no, specify (wheelchair, braces, etc.)_____

Communicable Disease ☐ Yes ☐ No If yes, explain_____

Please continue on reverse of page…

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REGISTERED CHARITABLE BUSINESS NUMBER 13454 2497 RR0001

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: _____