WindReach Farm

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

Physician Referral Form 2020

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 next 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: ____