# Physician's Referral

Please complete & return

**Name** _____ **Date of Birth** _____

**Occupation** _____

**Parent/Legal Guardian** _____

**Address** _____

**Street** **City** **State** **Zip**

**Diagnosis** _____ date of onset _____

**Medical History**:

_____

_____

_____

**Surgical Procedures:** _____

**Psychological** (include IQ where pertinent) _____

_____

**Medications:** _____

**Visual Impairments** _____ **Auditory Impairments** _____

**Speech Impairments** _____ **Circulation** _____

**Neuro-Sensation** _____

**Balance** _____ **Coordination** _____

**Spasticity and/or Rigidity** _____

**Braces** _____ **Assistive Devices** _____

**Seizures** _____ **Incontinence** _____

In my opinion, this patient can receive riding instruction under appropriate supervision.

**Precautions or Restrictions to therapeutic horseback riding** _____

_____

**Physician's Name** (print please): _____ **Phone:** _____

**Address** _____

**Street** **City** **State** **Zip**

****Physician's Signature**: _____ **Date** _____

****Form must be signed by the Physician**