



VALLEY THERAPEUTIC EQUESTRIAN ASSOCIATION

Physician Referral Form

Name of Rider: _____ Date of Birth: _____

Weight (lbs): _____ Height (ft/in): _____

Diagnosis/Disability: _____

Date of Onset: _____

How often should this form be updated/date: _____

(if not specified, VTEA policy is every 2yrs)

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		
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		
Tetanus Vaccine/Date		
Communicable Diseases		
Allergies		
Downs Syndrome & Rheumatoid Cervical Spine X-Rays (Sub-occipital & Atlanto/Axial Joints (Year)		
Flexion/Extension X-Rays Required (Year)		

Please note that if a rider has Down Syndrome an x-ray clearing him/her of Atlanto-Axial Instability must be taken and confirmed in letter form along with this referral form.

Precautions (if yes - please indicate):

Please note that there is a weight limit for riders at VTEA of 165lbs (with riding attire on).

Comments:

In my opinion, this patient can receive riding lessons under proper instruction. I understand that this patient may receive assessment/treatment by a physiotherapist, occupational therapist or psychologist in conjunction with this riding program regarding his/her physical and/or behavioral abilities/limitations in performing with the programme.

Physician's Name:

Physician's Signature:

Physician's Tel#

Date Form Completed: