Valley Therapeutic Equestrian Association
3330 256th St, Langley, BC, V4W 1Y4
Phone: 604-857-1267 Fax: 604-625-1268
Email: info@vtea.ca Website: www.vtea.ca

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/reviewed: _____
(if not specified, VTEA policy is every 2 years)

IMPAIRMENT(S):	YES/NO ABNORMAL/NORMAL	COMMENTS:
Auditory Impairments	_____	_____
Speech Impairments	_____	_____
Visual Impairments	_____	_____
Circulatory Impairments	_____	_____
Sensation	_____	_____
Incontinence – Bladder	_____	_____
Incontinence – Bowel	_____	_____
Assistive Devices	_____	_____
Psychological or Behaviour Concerns	_____	_____
Spinal/Joint Abnormalities	_____	_____
Hip Sublaxation 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/Date(s)	_____	_____
Tetanus Vaccine/Date	_____	_____
Communicable Diseases	_____	_____
Allergies	_____	_____
Down 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 165 lbs (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 program.

Physician's Name:_____ Phone #_____

Physician's Signature:_____ Date Form Completed:_____