PHYSICIAN PACKET

4246 W Highway 318
Citra, FL 32113
(904) 540-5853

Cara Gilison, OTD, OTR/L, AHCB
Occupational Therapist and Board Certified in Hippotherapy

(904)540-5853
4246 W Highway 318
Citra, FL 32113

Date: _____

Dear Health Care Provider:

Your patient is interested in participating in occupational therapy with integration of equine movement and equine activities.

_____
(participant's name)

In order to safely provide this service, our center requests that you complete/update the attached Medical History and Physician's Statement Form.

Please note that the following conditions may suggest precautions and contraindications to equine activities. Therefore, when completing this form, please note whether these conditions are present, and to what degree.

Orthopedic
Atlantoaxial Instability – include neurologic symptoms
Coxa Arthrosis
Cranial Deficits
Heterotopic Ossification/Myositis Ossificans
Osteoporosis
Pathologic Fractures
Spinal Joint Fusion/Fixation
Spinal Joint Instability/Abnormalities

Neurologic
Hydrocephalus/Shunt
Seizure
Spina Bifida/Chiari II Malformation
Tethered Cord/Hydromyelia

Other
Age – Under 4 years
Indwelling Catheters/Medical Equipment
Medications – i.e. Photosensitivity
Poor Endurance
Skin Breakdown

Medical/Psychological
Allergies
Animal Abuse
Cardiac Condition
Physical/Sexual/Emotional Abuse
Blood Pressure Control
Dangerous to self or others
Exacerbations of medical conditions (i.e. RA, MS)
Fire Settings
Hemophilia
Medical Instability
Migraines
PVD
Respiratory Compromise
Recent Surgeries
Substance Abuse
Thought Control Disorders
Weight Control Disorder

Thank you very much for your assistance.
If you have any questions or concerns regarding this patient's participation in equine assisted activities, please feel free to contact the center at the address/phone number indicated above.

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☐ Occupational Therapy ☐ Physical Therapy ☐ Speech Therapy ☐ Therapeutic Riding

PRESCRIPTION

Patient's Full Name:_____DOB:_____

Diagnosis: Please check one of the following. If more than one diagnosis applies, please number in order of importance. If diagnosis is specified, please note specific code.

___ Disorder of the Muscle, Unspecified (M62.9)
___ Ataxia, Unspecified (R27.0)
___ Congenital Malformation of Lung, Unspecified (Q33.9)
___ Cerebral Palsy, Unspecified (G80.9)
___ Disorder of Central Nervous System, Unspecified (G96.9)
___ Apraxia (R48.2)
___ Early-Onset Cerebellar Ataxia (G11.1)
___ Diffuse TBI w/out Loss of Consciousness (S06.2X0)
___ Autistic Disorder (F84.0)
___ PTSD (F43.10)
___ Major Depressive Disorder, Recurrent, Unspecified (F33.9)
___ Spina Bifida, Unspecified (Q05.9)
___ Spastic Diplegic Cerebral Palsy (G80.1)
___ Spastic Quadriplegic Cerebral Palsy (G80.0)
___ Specific Developmental Disorder of Motor Function (F82)
___ Infantile Spinal Muscular Atrophy, Type I (G12.0)
___ Diffuse TBI with Loss of Consciousness, Unspecified Duration (S06.2X9)
___ Anxiety Disorder, Unspecified (F41.9)
___Eating Disorder, Unspecified (F50.9)
___ Other (Specify Name and ICD-10 Code) _____

CONTRADICTIONS/PRECAUTIONS _____

Therapy is prescribed for the following treatment:

___Gross/Fine motor coordination via neuromuscular re-education or therapeutic activities
___Gait Training
___Sensory Integrative Activities
___Perceptual Activities
___Therapeutic Exercise

Frequency:_____ Duration:_____

Physician's Name:_____ NPI Number:_____
(Please Print)

Physician's Phone #:_____ Fax #:_____

Physician's Signature:_____

Address:_____

Date:_____

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Medical Information Form

Name: _____ Date of Birth: _____

Address: _____

Phone Number: _____ Name of Parent/Guardian: _____

Diagnosis: _____ Date of Onset: _____

** ***For persons with Down Syndrome:***

☐ Negative Cervical X-ray for Atlantoaxial Instability X-ray Date: _____

☐ Negative for clinical symptoms of Atlantoaxial Instability

Tetanus Shot: ☐ Yes ☐ No Date: _____ Height: _____ Weight: _____

Seizure

Type: _____ Controlled: _____ Date of Last Seizure: _____

Medications: _____

Please indicate if patient has a problem or surgeries in any of the following areas by checking yes or no. If yes, please comment.

Areas	Yes	No	Comments
Auditory			
Visual			
Speech			
Cardiac			
Circulatory			
Pulmonary			
Neurological			
Muscular			
Orthopedic			
Allergies			
Learning Disability			
Mental Impairment			
Psychological Impairment			
Other			

Mobility:

Independent Ambulation	Crutches/Cane	Braces	Wheelchair
☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

Please indicate any special precautions: _____

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To my knowledge there is no reason why this person cannot participate in supervised equestrian activities. However, I understand that Therapy on Hooves will weigh the medical information above against the existing precautions and contraindications.

I concur with a review of this person's abilities/limitations by a licensed/credentialed health professional (e.g. PT, OT, Speech, Psychologist, etc.) In the implementing of an affective equestrian program.

Patient Name (please print) _____

Physician Name (please print) _____

Physician Signature _____

Address_____City_____State_____Zip _____

Phone (_____)_____