NEW HOPE EQUINE ASSISTED THERAPY

Medical Healthcare Professional Statement

Must be completed, signed and diagnosis confirmed by Licensed Medical Professional

Name:_____ DOB: _____ Height: _____ Weight: _____

Seizure Type: _____ Controlled_____ Date of last Seizure:_____

Diagnosis _____

Medications:_____
Shunt Present: Yes No Date of last shunt revision: _____

Past/Prospective surgeries:_____

Mobility: Independent Ambulation Assisted Ambulation Wheelchair

Braces/Assistive Devices: _____

For those with Down Syndrome: Neurologic Symptoms of AtlantoAxial Instability: ____*Present ____*Absent

Please indicate current or past special needs in the following systems/areas, including surgeries.

	Y	N	Comments pertaining to horseback riding/Equine interaction
Auditory			
Visual			
Tactile Sensations			
Speech			
Cardiac			
Circulatory			
Integumentary/Skin			
Immunity			
Pulmonary			
Neurologic			
Muscular			
Balance			
Orthopedic			
Allergies			
Learning Disability			
Cognitive			
Emotional/Psychological			
Pain			
Other			

Given the above diagnosis and medical information, to my knowledge there is no reason why this person cannot participate in supervised equestrian activities. I understand that New Hope Equine Assisted Therapy will weigh the medical information given against the existing precautions and contraindications. Therefore, I refer this person to New Hope Equine Assisted Therapy for ongoing evaluation to determine eligibility for participation.

***Physician Signature: _____* Licensed Medical Professional MD, DO, NP, PA, Other**

Physicians Name (please print) _____Date: _____

Address: _____

Phone: ( ) _____ *License/UPIN # _____

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