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| Patient Name: | |  | | | | | | | | | | |  | | DOB | | |  | | | |  | | HC# | |  | | | | M F    M F | |
|  | |  | | | | | | | | | | |  | |  | | |  | | | |  | |  | |  | | | |  | |
| Last First | | | | | | | | | | | | |  | | dd mm yyyy | | | | | | |  | |  | | | | | |  | |
|  | | | | | | | | | | | | |  | |  | | | | | | |  | | Weight:\_\_\_\_\_\_\_\_\_\_\_\_\_ (lbs) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | Height: \_\_\_\_\_\_\_\_ (ft) | |
|  |  | | | | | | | | | |  |  | | | | | | | |  |  | | | | | |  | |  | | |
| Address: |  |  |  | |
|  | # Street / # Apt | | | | | | | | | |  | City | | | | | | | |  | Postal Code | | | | | |  | | Phone Number | | |
|  |  | | | | | | | |  | | | | | | | |  | |  | | | | | | | | |  | | | |
| Date: |  | Language Preferred: | | | | | | | Next of Kin/Guardian: | | | | | | | | | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | |
| **Individual Living** | | | independent | | | | | with parents/guardian | | | | | |  | | Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | | | | |  | |
| **Diagnosis** | | | Primary: | | | | Date of onset: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | | | | | | | | | | | | | |
| Secondary: | | | | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of onset: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  ***\*Please note that a cervical x-ray is required for rider with diagnosis of Down’s Syndrome.*** | | | | | | | | | | | | | | | | | | | | | | | |
| **Medical Concerns**  (please circle) | | | Health Status Cardiac Disease Incontinence Depression Circulation Muscle tone    \*Diabetic (insulin: yes no) \*Epileptic (frequency of seizures?): \_\_\_\_\_\_\_\_\_ (date of last seizure): \_\_\_\_\_\_\_\_\_\_  Triggers: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Behavioural Concerns**  (please circle) | | | withdrawal anxiety agitation aggressiveness (verbal / physical) depression  delusions hallucinations paranoid smoking anger attention deficits | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Sensory Concerns**  (please circle) | | | gait/ balance/coordination sensation concerns visual impairment auditory impairment ambulatory / non-ambulatory  Sensory aids: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Mobility aids: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Communicable Disease | | | No: \_\_\_\_\_ Yes: \_\_\_\_ (please explain)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Allergies | | | No: \_\_\_\_\_ Yes: \_\_\_\_\_ (please list) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Medications/specify use** | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Surgery** | | |  |  |  | No: \_\_\_\_\_\_ Yes: \_\_\_\_\_ Type of surgery: 1)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  2) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  3) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | | | | | | |  | | Date(s): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | |
|  | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Other Concerns** | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | |

In my opinion, this patient can receive riding instruction under appropriate supervision. He/she may be evaluated further by the program therapist for evaluation of his/her physical abilities and or limitations in performing exercises and riding skills: yes / no.

Precautions/Contradictions: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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| --- | --- | --- | --- | --- | --- | --- |
| **Referring Physician:** |  | |  |  |  |  |
| Name/ Please print | |  | Signature |  | Date |
|  |  |  | | | |  |
|  |  | |  |  |  |  |
| *This document contains confidential information. If it is received in error please notify STRP immediately at (705) 560-7877. Thank you* | Address | |  | Phone |  | Fax |