|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Patient Name: |  |  | DOB  |  |  | HC# |  |  M FM 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) depressiondelusions hallucinations paranoid smoking anger attention deficits |
|  **Sensory Concerns**(please circle) | gait/ balance/coordination sensation concerns visual impairment auditory impairment ambulatory / non-ambulatorySensory 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: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  **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 |