Physician Referral

Sudbury Therapeutic Riding Program (STRP) 2019
Mailing Address: PO Box 2212
Station A, Sudbury Ont.
P3A 4S1
Phone: (705) 560-7877 Website: www.strp.ca

Patient Name: ______________________ DOB ____________ HC# ____________ 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 riders 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**:** ______________________

Referring Physician:

______________________ ______________________ ____________

Name/ Please print Signature Date

______________________ ______________________ ____________

Address Phone Fax

This document contains confidential information. If it is received in error please notify STRP immediately at (705) 560-7877. Thank you