

WindReach Farm

A centre for inclusion and personal achievement for people of all abilities.

www.windreachfarm.org

Physician Referral Form 2021

Rider Name _____ Date of Birth _____

Address _____ Postal Code _____

Phone Number _____ Email Address _____

Name of Disability _____

Primary Diagnosis _____

Secondary Diagnosis _____

Height _____ Weight _____ (The maximum weight of any rider must not exceed 180 lbs or 81 kg)

Diabetic: Yes No Insulin: Yes No Continence: Yes No

Epileptic Yes No If yes, indicate type & frequency of seizures _____

Date of last seizure _____ ****Rider/Guardian please complete a Seizure Release Form****

Cerebral Palsy Yes No If yes please specify: Monoplegia Diplegia Quadriplegia Hemiplegia (which side L R)

General Health _____

Medications _____

Atlanto-Axial X-Ray Verification for Riders with Down Syndrome

Due to the nature of this activity (horseback riding lessons), Down Syndrome with an atlanto-axial instability is a contraindicated condition. A negative atlanto-axial instability x-ray is required. If the rider has Down Syndrome this form must be signed and dated by a qualified physician giving the date and result of the diagnostic X-ray.

This client does not have Down Syndrome

This client has Down Syndrome Date of X-Ray: _____

Result of X-Ray: _____

Allergies _____

Surgery & Dates _____

Ambulatory Yes No If no, specify (wheelchair, braces, etc.) _____

Communicable Disease Yes No If yes, explain _____

Please continue on next page...

Physician Referral Form Continued

Tone: Upper extremities _____ Trunk _____ Lower extremities _____

Can the patient sit independently? Yes No Can they grasp with their hands? Yes No

Visual Impairments: _____

Balance (Good, Fair, Poor, None): Sitting _____ Standing _____ Walking _____

Language: English Other (spoken) _____ Sign Language Yes No Other _____

Speech: Good _____ Fair _____ Poor _____ Non Verbal _____

Ability to understand: Good Fair Poor Comments: _____

Is there any reason why this person should be precluded from a therapeutic riding program?

When do you recommend that this form be updated? Every year Every two years Other: _____

Physician's Signature _____ Date _____

Physician's Name (please print clearly) _____

Address _____ City _____ PC _____

Telephone # _____ Fax # _____

To be completed by the parent/guardian or rider of legal age:

Information Release

I hereby authorize The Stables at WindReach Farm to release to its instructors and volunteers such information as may be necessary to conduct a beneficial and safe riding program.

Name of Rider: _____

Date: _____

Signed: _____

Relation to Rider: _____

Witness: _____