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DREAM THERAPIES
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Date:

Dear Physician:

Your patient, _____ is
_____ Interested in participating in Hippotherapy
_____ Interested in continuing to participate in Hippotherapy
_____ Interested in participating in therapeutic riding
_____ Interested in continuing to participate in therapeutic riding

In order to safely provide this service, our program requests that you circle any conditions below that your client has. These conditions may suggest, but do not guarantee, precautions or contraindications to Hippotherapy/therapeutic riding.

Orthopedic Conditions

Atlantoaxial instability
Coxa arthrosis
Cranial bone defects
Heterotopic ossifications
Myositis ossifications
Joint subluxation-dislocation
Osteoporosis
Spinal Fusion- Fixation
Spinal Instability/ abnormalities

Medical/ Psychological Conditions

Allergies to animals
Animal abuse
Poorly controlled high/low blood pressure
Pyromania/fire setting
Cardiac condition: _____
Hemophilia
Migraines
Peripheral Vascular Disease
Respiratory compromise

Neurological Conditions

Hydrocephalus/ Shunts
Seizures: _____
Spina Bifida
Arnold Chiari Malformation

Other

Indwelling Catheter
Photosensitivity (incl. med side effect)
Skin breakdown _____

Recent Surgeries: _____

Other: _____

To my knowledge there is no reason why this person cannot participate in supervised equestrian activities. I occur with a review of this person's abilities/limitations by a licensed/credentialed health professional e.g. Occupational or Physical Therapist in the implementation of an effective program.

PHYSICIAN SIGNATURE:

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Physician's Orders

Name: _____

Date of Birth: _____

Diagnosis: _____

Today's date: _____

_____ Occupational Therapy evaluation and treatment

_____ Physical Therapy evaluation and treatment

Other:

Physician's Signature

Name/Title