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Equine Assisted Activities & Therapies
Physician's Referral

CHUM Therapeutic Riding
PO Box 14
Mason, MI 48854

Phone: (517)204-0974
Email: bonnieandchum@gmail.com

Date signed

Rider's Name Date of Birth

Address Height Weight

Parent/Guardian

The C.H.U.M. Therapeutic Riding Inc. program is a PATH Intl. Premier Accredited Therapeutic Riding Center designed to benefit the riders physically, socially, and emotionally. Only certified therapeutic riding instructors who meet the requirements are qualified to teach in the program. Appropriate safety equipment is used at all times. Volunteers and horses are trained to meet the needs of the riders. In order to ensure the rider the fullest possible protection and greatest personal benefit from the program, **every rider with a disability is required to furnish the following medical information before being accepted as a riding student**.

Diagnosis Date of Onset

If diagnosis is Down's Syndrome, this form must be accompanied by *one* of the following documents OR acknowledgements:

1. Neurologic Symptoms of AAI - Present ◯ Absent ◯
2. Therapeutic Riding Down's Syndrome Rider Evaluation
3. A signed, dated statement from a qualified physician giving the date and result of a diagnostic X-ray for Atlanto-Axial Dislocation Condition

Note: Because of the nature of the equine activities and therapies, no one diagnosed as having Down's Syndrome can be accepted for riding instruction without proof of a negative diagnostic X-ray for Atlanto-Axial Dislocation Condition OR negative Neurologic Symptoms of AAI.

Mobility:
Independent ambulation – Y ◯ N ◯ Assistive device for ambulation – Y ◯ N ◯ Wheelchair – Y ◯ N ◯

Medical history:

Past/prospective surgeries:

Medication (Name, Purpose, Dosage):

Allergies:

Deficits present in: Cardiac ☐ Sight ☐ Hearing ☐ Speech ☐ Neuro-sensation ☐ Muscle ☐
Orthopedic ☐ Balance ☐ Coordination ☐ Respiratory ☐

Inhaler needed: Y ◯ N ◯ **Pain:** Always ◯ Sometimes ◯ Rarely ◯

Are braces or other devices used (G/J tubes, Osteotomy, etc.)? Y ◯ N ◯ Specify

Comment if applicable:

Seizures – Type Controlled? Y ◯ N ◯ Date of last seizure:

Shunt Present: Y ◯ N ◯ Date of last revision: Incontinence

General Comments:

In my opinion, the patient named can receive therapeutic riding instruction under appropriate supervision.

Physician's signature Date

Address Phone