Free Rein Therapeutic Riding

PO Box 30893
Spokane, WA 99223
Phone: 509-979-1468
Fax: 509-381-4164
Email: info@FreeReinSpokane.org
Website: www.freereinspokane.org

Participant's Consent for Release of Information

I hereby authorize: _____
(Physician's Name and Facility)

to release information from the records of: _____ DOB: _____
(Participant's Name)

The information above is to be release to Free Rein Therapeutic Riding for the purpose of developing an equine activity program for the above named participant. The information to be released is indicated below:

Medical History

Physical Therapy evaluation, assessment and program plan

Speech Therapy evaluation, assessment and program plan

Mental Health diagnosis and treatment plan

Individual Habilitation Plan (I.H.P.)

Classroom Individual Education Plan (I.E.P.)

Psychosocial evaluation, assessment and program plan

Cognitive-Behavioral Management Plan

Other: _____

This release is valid until revoked in writing, at my request.

Signature: _____ Date: _____

Print Name: _____

Relationship to Participant: _____

Please mail materials to: Free Rein Therapeutic Riding
PO Box 30893
Spokane, WA 99223
Or fax to: 509-381-4164

Free Rein Therapeutic Riding

Date: _____

Dear Health Care Provider,

Your patient _____
is interest in participating in supervised equine activities. In order to safely provide this service, our cent requests that you complete/update the attached Medical History and Physician's Statement Form. Please note that the following conditions may suggest precautions and contraindications to equine activities. Therefore, when completing this form, please not whether these conditions are present, and to what degree.

Orthopedic

Atlantoaxial Instability
-include neurological symptoms
Coxa Arthrosis
Cranial Deficits
Heterotopic Ossification
Osteogenesis Imperfecta
Joint subluxation/dislocation
Osteoporosis
Pathological Fractures
Spinal Joint Fusion/Fixation
Spinal Joint Instability/Abnormalities
Internal Spinal Stabilization Devices
(such as Harrington Rods)
Scoliosis
Kyphosis
Lordosis

Neurological

Hydrocephalus/Shunt
Uncontrolled Seizure Disorders
Spina Bifida
Chiari II Malformation
Tethered Cord
Hydromyelia
Paralysis due to Spinal Cord Injury (above T-9)

Other

Age – under 4
Indwelling Catheters/Medical Equipment
Medications – i.e. photosensitivity
Poor Endurance
Skin Breakdown
Behavioral Problems

Thank you very much for your assistance. If you have any questions or concerns regarding this patient's participation in equine assisted activities, please feel free email us at info@freereinspokane.org, or call at 509-979-1468.

Sincerely,
Kate McCloskey
Program Director

Free Rein Therapeutic Riding

Participant's Medical History and Physician's Statement

Name: _____ DOB: _____

Address: _____ Phone: _____

Gender: _____ Height: _____ Weight: _____

Diagnosis: _____ Date of Onset: _____

Cause: _____

Past/Prospective Surgeries: _____

Medications (Type, purpose, dose): _____

_____

Seizure Type: _____ Controlled: Y N

Date of Last Seizure: _____

Shunt Present: Y N Date of last revision: _____

Special Precautions/Needs: _____

_____

For those with **Down Syndrome:**

- € Participant shows **NO EVIDENCE** of neurological symptoms or physical findings associated with atlantoaxial instability (AAI).
- € Participant has neurological symptoms or physical findings that could be associated with atlantoaxial instability and must receive an additional neurological evaluation to rule out additional risk of spinal cord injury prior to clearance for participation in equestrian activities.

Mobility: Independent Ambulation Y N Assisted Ambulation Y N Wheelchair Y N

Braces/Assistive Devices: _____

Please indicate current or past special needs in the following systems/area, including surgeries. If more space is needed, please attach additional page.

	YES	NO	Comments
Auditory			
Visual			
Tactile Sensation			
Speech			
Cardiac			
Circulatory			
Integumentary/Skin			
Immunity			
Pulmonary			
Neurological			
Muscular			
Balance			
Orthopedic			
Allergies			
Learning Disability			
Cognitive			
Emotional/Psychological			
Pain			
Other			

Given the above diagnosis and medical information, this person is not medically precluded from participating in equine assisted activities. I understand that Free Rein will weigh the medical information given against the existing precautions and contraindications. Therefore, I refer this person to Free Rein for ongoing evaluation to determine eligibility for participation.

Name/Title: _____ MD DO NP PA Other_____

Signature: _____ Date: _____

Address: _____

Phone: _____ Fax: _____

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PHYSICAL/OCCUPATIONAL THERAPY ASSESSMENT*

*__This form is not mandatory__, but is helpful for our instructors when assessing riders.

Please complete and return to Free Rein at mailing address above, a current PT or OT evaluation would also be an acceptable alternative.

Name: _____ DOB: _____

Diagnosis: _____

History of therapy intervention: _____

_____

Please describe the following functional abilities:

Sitting balance (head/trunk control, balance reaction, support needed): _____

_____

ROM Measurements: _____

Mobility (with and without assistive devices): _____

_____

Sensory systems: _____

_____

Equipment (when first used, purpose, present use): _____

_____

Communications methods used: _____

Present primary therapy goal: _____

_____

Precautions and/or contraindications: _____

_____

Signature & Title: _____ Date: _____

Therapist Name (Please Print): _____ Phone: _____

School, Center or Organization: _____Phone: _____

Address: _____City:_____ Zip: _____