5001 CR Wood Rd Gastonia, NC 28056
Phone : (704) 862-0095 | Email: BitofHopeRanch@yahoo.com
www.BitofHopeRanch.org

CHA Site Accredited

Bit of Hope Ranch Medical Forms

Date: _____

Dear Health Care Provider:

Your patient, _____, is interested in participating supervised equine activities.

In order to safely provide this service, our center requests that you complete/update the attached Medical History, Physician's Statement, and Physician's Prescription Forms. Please note that the following conditions may suggest precautions and contraindications to equine activities. Therefore, when completing this form, please note whether these conditions are present, and to what degree.

Orthopedic
- Atlantoaxial Instabilities
- Coxas Arthrosis
- Cranial Deficits
- Heterotopic Ossification/Myositis Osifications
- Internal Spinal Stabilization Devices
- Joint Subluxation and Dislocation
- Kyphosis
- Lordosis
- Osteoporosis
- Osteogenesis Imperfecta
- Pathologic Fractures
- Spinal Joint Fusion/Fixation
- Spinal Joint Instabilities/Abnormalities
- Scoliosis
- Spinal Orthoses

Secondary Concerns
- Behavior problems
- Age less than two years
- Age two – four years
- Acute exacerbation of chronic disorder
- Poor Endurance
- Skin Breakdowns
- Indwelling Catherers/Medical Equipment

Neurological
- Chiari II malformation
- Hydrocephalus/shunt
- Hydromyelia
- Paralysis due to Spinal Cord injury
- Seizure Disorders
- Spina Bifida
- Tethered Cord
- Medications – i.e. photosensitivity

Medical/Surgical/Psychological
- Allergies
- Animal Abuse
- Blood Pressure Control
- Cancer
- Cardiac Condition
- Dangerous to self or others
- Diabetes
- Exacerbations of medical conditions (i.e. RA, MS)
- Fire Settings
- Hemophilia
- Hypertension
- Medical Instability
- Migraines
- Peripheral Vascular Disease
- Respiratory Compromise
- Recent Surgeries
- Varicose Veins
- Substance Abuse
- Thought Control Disorders
- Weight Control Disorder

Stroke (Cerebrovascular Accident)

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 to contact the center at the address/phone indicated above.

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Participant's Medical History & Physician's Statement

Participant: _____ DOB: _____ Height: _____ Weight: _____

Address: _____

Diagnosis: _____ Date of Onset: _____

Past/Prospective Surgeries: _____

Medications: _____

Seizure Type: _____ Controlled: Y N Date of Last Seizure: _____

Shunt Present: Y N Date of last revision: _____

Special Precautions/Needs: _____

_____

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

Braces/Assistive Devices: _____

For those with Down Syndrome: AtlantoAxial Instability X-Ray, Date: _____ Result: + --

Nuerological Symptoms of AtlantoAxial Instability: _____

Please indicate current or past special needs in the following systems/areas, including surgeries:

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

To my knowledge there is no reason why this person cannot participate in supervised equestrian activities. However, I understand that the therapeutic riding center will weigh the medical information above against the existing precautions and contraindications. I concur with a review of this person's abilities/limitations by a licensed/credentialed health professional (e.g. PT, OT, Speech, Psychologist, etc.) in the implementing of an effective equestrian program.

Physician's Name (please print): _____ MD DO NP PA Other _____

Physician's Signature: _____ Date: _____

Address: _____ City: _____ State: _____ Zip: _____

Phone: _____ Fax: _____ License/UPIN Number: _____

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Prescription Form

Client's Full Name _____

Date of Birth _____/_____/_____ **Phone**_____

Please Check Appropriate Boxes:

□Prescription, for Hippotherapy where appropriate for evaluation and treatment by a Physical, Occupational and/or Speech Therapist in conjunction with the Therapeutic Horseback Riding Program at Bit of Hope Ranch.

☐ **Occupational Therapy** ☐ **Physical Therapy** ☐ **Speech Therapy**

Frequency 1 X WK 45 minutes

Duration 1 Year

Effective Date _____

☐ **Equine Assisted Activities/Therapeutic Riding** (Taught by a PATH Certified Instructor)

Precautions (*All individuals riding are required to wear helmets*)

_____

_____

Physician's Name (Print) _____

Physician's Signature _____**Date**_____/_____/_____

Carolina Access Provider # _____

National Provider # _____

License/UPIN Number _____

Physician's Address _____

_____

Physician's Phone _____

Fax _____