



PARD Therapeutic Riding

MEDICAL REFERRAL

Name: _____ Date of Birth: _____

Primary Diagnosis: _____

Secondary Diagnosis: _____

Height: _____ Weight: _____ Diabetic: _____ Insulin: _____

Seizures Y or N If yes, indicate type and frequency of seizures: _____

Date of last seizure: _____

General Health: _____ Continence: _____

Mediations: _____

Allergies: _____

Surgeries: _____ Dates: _____

Ambulatory Y or N Explain (wheelchair, braces, orthotics...): _____

Tone: Upper extremities: _____ Trunk: _____

Lower extremities: _____

Balance: Sitting: _____ Standing: _____ Walking: _____

Language: English _____ Sign Language _____ Other _____

Speech: Good _____ Fair _____ Limited _____ Non-verbal _____

Ability to understand: Good _____ Fair _____ Limited _____

Sensory function present: Sight: _____ Hearing: _____ Tactile: _____

Comments: _____

I hereby refer the above individual to the riding program of PARD Therapeutic Riding.

Physician's signature: _____ Date: _____

Physician's Name (please print clearly): _____

Address: _____ City: _____ Postal Code: _____

Telephone: _____ Fax: _____