

Naples Equestrian Challenge, Inc.

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ANNUAL PHYSICIAN'S REFERRAL FORM

EXPIRES August 31, 2011

Rider's Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Date of Birth: _____ Height: _____ Weight: _____

Parent/Guardian: _____ Phone: _____

Naples Equestrian Challenge, Inc. is a therapeutic riding program designed to benefit the riders physically, socially, and emotionally. Safety equipment and specially trained horses and volunteers are used. In order to assure the fullest possible protections and greatest personal benefit from the program, each rider is required to furnish the following medical information before being accepted as a rider.

Diagnosis: _____ Date of Onset: _____

Note: If the diagnosis is Down Syndrome, the first Physician's Referral Form ever submitted to NEC, Inc. must be accompanied by a negative diagnosis x-ray report for Atlantoaxial Instability. This must be a signed statement from a qualified physician giving the date and result of the x-ray. If you have questions, please call us.

Medical History: _____

Allergies: _____

Surgical Procedures: _____

Medications: _____

Prescribed For: _____

Present Impairments (Please Check Yes or No for each category):

Impairment	Yes	No
Sight		
Hearing		
Speech		
Sensory		
Balance		
Muscle Tone		
Coordination		
Mobility		
Braces or Assistive Devices		
Spasticity and/or Rigidity Present		
Seizures (if yes, date of last one)		

In my opinion this patient can receive riding instruction under supervision. In conjunction with the riding program, I concur in the referral of the patient to the physical therapist for evaluation of his/her physical abilities and/or limitations in performing exercises.

Precautions or Contraindications to Physical Therapy: _____

Physician's Signature: _____

Printed Name: _____

Dated this _____ day of _____, 20_____

(Physician's Stamp)

NEC Date Received: _____

Staff Initials: _____