



### Physician's Statement

Participant: \_\_\_\_\_ DOB: \_\_\_\_\_ Height: \_\_\_\_\_ Weight: \_\_\_\_\_

Address: \_\_\_\_\_

Diagnosis: \_\_\_\_\_ Date of Onset: \_\_\_\_\_

Past/Prospective Surgeries: \_\_\_\_\_

Medications: \_\_\_\_\_

Seizure Type: \_\_\_\_\_ Controlled: Y N Date of Last Seizures: \_\_\_\_\_

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: AtlantoDens Interval X-rays, date: \_\_\_\_\_ Result: + -**

Neurologic Symptoms of AtlantoAxial Instability: \_\_\_\_\_

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

	Y	N	Comments
<b>Auditory</b>			
<b>Visual</b>			
<b>Tactile Sensation</b>			
<b>Speech</b>			
<b>Cardiac</b>			
<b>Circulatory</b>			
<b>Integumentary/Skin</b>			
<b>Immunity</b>			
<b>Pulmonary</b>			
<b>Neurologic</b>			
<b>Muscular</b>			
<b>Balance</b>			
<b>Orthopedic</b>			
<b>Allergies</b>			
<b>Learning Disability</b>			
<b>Cognitive</b>			
<b>Emotional/Psychological</b>			
<b>Other</b>			

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

Name: \_\_\_\_\_ MD DO NP PA Other \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

License/UPIN Number: \_\_\_\_\_

Address: \_\_\_\_\_ Phone#: \_\_\_\_\_