Affinity Ranch
11892 Hilltop Rd
Parker, CO 80134
(303) 841-4043
www.affinityranch.org

Dear Healthcare Provider:

Your patient is interested in participating in supervised equine activities/therapies. To safely provide this service, Affinity Ranch requests that you complete the attached Medical History and Physician's Statement Form. Please note that the following conditions may suggest precautions and contraindications to equine activities/therapies. Therefore, when completing this form, please note whether these conditions are present, and to what degree.

Orthopedic

- Atlantoaxial instability - include neurologic symptoms
- Coxarthrosis
- Heterotopic Ossification/Myositis Ossificans - Cranial Defects/Deficits
- Joint Subluxation/Dislocation - Osteoporosis - Pathologic Fractures
- Spinal Joint Fusion/Fixation - Spinal Instability/Abnormalities

Neurologic

- Hydrocephalus/Shunt - Seizure
- Spina Bifida/Chiari II
- Malformation/Tethered Cord/hydromyelia

Medical

- Allergies - Hemophilia - Medical Instability - Migraines - Peripheral Vascular Disease
- Respiratory Compromise - Recent surgeries - Weight Control Disorders
- Cardiac Condition - Blood Pressure Control - Exacerbations of Medical Conditions

Psychological

- Animal Abuse - Physical/Sexual/Emotional Abuse
- Fire Setting - Danger to Self or Others - Substance Abuse
- Thought Control Disorder

Other

- Age - less than 4 years - Indwelling catheters/Medical Equipment
- Medications (Photosensitivity) - Poor Endurance - Skin Breakdown

Please complete the following forms on pages 2-4 and email to client@affinityranch.org. Or fax to 720-783-2776.

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Medical History and Physician's Statement

Participant: _____

DOB: _____ Height: _____

Weight:_____Gender: _____

Primary Diagnosis: _____

Date of Onset:_____

Past Surgeries: _____

Prospective Surgeries: _____

Medications and Purposes: _____

_____

_____

Seizures: Yes/No Controlled: Yes/No

Type _____ Date of Last Seizure: _____

Shunt Present: Yes/No Date of Last Revision: _____

Mobility Type: Independent Assisted Ambulation
Wheelchair

Braces/Assistive Devices: _____

Special Precautions/Needs: _____

Continued on next page

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

	Yes	Comments
Auditory		
Visual		
Tactile		
Cardiac		
Circulatory		
Pulmonary		
Immunity		
Integumentary/Skin		
Muscular		
Orthopedic		
Allergies		
Pain		
Balance		
Learning/Development		
Cognitive		
Speech/Language		
Psychological/Emotional/Behavioral		
Neurologic		
Other		

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Physician's Authorization

Given the patient's diagnosis and medical information:

____Yes, this patient can participate in the Affinity Ranch Adaptive Horsemanship Program or Equine Assisted Therapy Program, under appropriate supervision.

____No, this patient should not participate in Affinity Ranches Adaptive Horsemanship Program or Equine Assisted Therapy Program.

Physician's Information

Signature: _____ Date: _____

Name/Title: _____ MD/DO/NP/PA/Other: _____

Business Address: _____

Phone: _____

License/UPIN Number: _____

FOR INDIVIDUALS WITH DOWN SYNDROME ONLY:

Because of the nature of horseback riding, no individual diagnosed with Down Syndrome can be accepted for any equine-assisted activity or therapy without proof of a negative diagnostic X-ray for Atlantoaxial Instability.

Physician's Acknowledgement:
I have X-rayed this patient for Atlantoaxial Instability and the results are negative. In addition, this patient does not display any neurologic signs or symptoms of this condition and may participate in the Affinity Ranch Adaptive Horsemanship or Equine-Assisted Therapy Programs.

Date of Last X-ray: _____

Physician Signature: _____Date: _____