



A Community Service Program Sponsored by

Green Horse

PO Box 1281
Ashland, OR 97520

541.482.6210
trish@trishbroersma.com
www.trishbroersma.com

Date:

Dear Health Care Provider:

Your patient

is interested in participating in supervised equine activities.

In order to safely provide this service, our program requests that you complete/update the attached Medical History and Physician's Statement Form. 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 Instability - include neurologic symptoms

Coxarthrosis

Cranial Defects

Heterotopic Ossification/Myositis Ossificans

Joint subluxation/dislocation

Osteoporosis

Pathologic Fractures

Spinal Joint Fusion/Fixation

Spinal Joint Instability/Abnormalities

Neurologic

Hydrocephalus/Shunt

Seizure

Other

Indwelling Catheters/Medical Equipment

Medications - e.g., Photosensitivity

Poor Endurance

Skin Breakdown

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 me at the address/phone indicated above.

Sincerely,

Trish Broersma

Director, Green Horse and Riding Beyond

Medical/Psychological

Allergies

Weight Control Disorder

Cardiac Condition

Thought Control Disorders

Blood Pressure Control

Dangerous to Self or Others

Exacerbations of Medical Conditions (e.g., RA, MS)

Substance Abuse

Hemophilia

Medical Instability

Migraines

PVD

Respiratory Compromise

Recent Surgeries

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: _____
 Special Precautions/Needs: _____

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

Braces/Assistive Devices: _____

Please indicate current or past special needs in the following systems/areas, including surgeries. These conditions may suggest precautions and contraindications to equine activities.

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

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

Name/Title: _____ MD DO NP PA Other _____

Signature: _____ Date: _____

Address: _____

Phone: (_____) License/UPIN Number: _____