

Briggs Stable
Therapeutic Riding Division

623 Hanover Street, Rte. 139

Tel: 781-826-3191

Fax: 781-829-0091

Information for Physician

Below is a list of conditions that need to be taken into consideration before allowing therapeutic horseback riding. These conditions, if present, may bring precautions and/or contraindications to therapeutic horseback riding. Please note on the following form whether or not these conditions are present and to what degree.

Orthopedic

Coxas Arthrosis
Cranial Deficits
Heterotopic Ossification
Hip Subluxation and Dislocation
Internal Spinal Stabilization Devices
Kyphosis
Lordosis
Osteogenesis Imperfecta
Osteoporosis
Pathological Fractures
Scoliosis
Spinal Abnormalities
Spinal Fusion
Spinal Instabilities
Spinal Orthoses

Neurologic

Chiari II Malformation
Hydrocephalus/ Shunt
Hydromyelia
Microcephalus
Paralysis due to Spinal Cord Injury
Seizure Disorder
Spina Bifida
Tethered Cord

Medical / Surgical

Allergies
Cancer
Diabetes
Hemophilia
Hypertension
Peripheral Vascular Disease
Poor Endurance
Recent Surgery
Serious Heart Condition
Stroke (Cerebrovascular Accident/ Injury)
Varicose Veins

Secondary Concerns

Acute Exacerbation of chronic disorder
Age: under two years
Age: two - four years
Behavioral Problems
Indwelling catheter
Severe Psychological Condition

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Riding Authorization
Riders' Medical History and Physician Statement

This form must be completed by a licensed physician in order for a rider to participate in therapeutic riding lessons at Briggs Stable. Forms need to be updated annually.

Date: _____

DOB _____/_____/_____

Rider's Name: _____

Day Phone: _____

Address: _____

Cell Phone: _____

Parent's Name: _____

Diagnosis: _____

Date of Onset: _____

Height: _____

Weight: _____

Tetanus Shot: Yes _____ No _____ Date _____

Medications: _____

Side effects: _____

FOR RIDERS WITH DOWN SYNDROME ONLY:

Negative Cervical X-Ray for Atlantoaxial Instability Yes _____ No _____

Negative for Clinical Symptoms of Atlantoaxial Instability Yes _____ No _____

X-Ray Date: _____

Riders and Caregivers are urged to voluntarily enclose an up to date copy of the vaccination records along with this form.

Please indicate if the rider has/had a problem and or surgeries in any of the following areas. If yes, then please provide a comment.

Areas	Yes	No	Comments
Allergies			
Auditory			
Cardiac			
Circulatory - PVD - Postural Hypotension			
Hemophilia			
Hydrocephalus - Shunt			# of revisions: Date of last revision:
Learning Disability			
Mental Impairment			
Muscular - Contractures			Botox Injections?
Neurological - Seizures - Controlled ?			Last Seizure:
Orthopedic			
Pain - Where - What degree			
Psychological Impairment - Severity - Therapy			Are there any triggers or things to avoid?
Pulmonary - Asthma/ COPD			
Sensory Loss			
Speech			
Visual			Glasses Y_____ No_____
Other			
PLEASE CONTINUE ON TO THE NEXT PAGE			

Skeletal Information	Yes	No	Explain Degree and Comment
Down Syndrome only Evidence of Spinal Cord Compression			
Braces			Last X-Ray:
Cranial Defects			
Dislocating Joints			
Fractures - Location - Healed (date)			
Heterothrophis/Ossification			
Joint Disease			
Kyphosis/ Lordosis Type			Degree:
Laminectomy/Fusion			
Medications			
Osteoporosis			
Subluxing Joints			
Scoliosis/ Degree/ Type			
Spinal Abnormality			
Spinal Column Injury			
Spondylolistheses			
Other			

Mobility:

Ambulatory: Yes _____ No _____

Independently: Yes _____ No _____

Crutches: Yes _____ No _____

Braces: Yes _____ No _____

Wheelchair: Yes _____ No _____

Prosthetics: Yes _____ No _____

Purpose: _____

Special Precautions: _____

Please include any additional information that may help us with our success with your client. Thank you. _____

Riding Authorization

To be signed by the physician. Stamps are not accepted.

To my knowledge there is no reason why _____ cannot participate in supervised equestrian activities and events. However, I understand that the Therapeutic Riding Instructor at Briggs Stable will review and weigh the medical information above against the existing precautions and contradictions set by NARHA. I concur with a review of this person's abilities/limitations by a licensed/ credentialed health professional (PT, OT, Speech, Psychologist, etc.) in the implementing of an effective equestrian program.

Please **initial** one of the following options

I **do recommend** horseback riding for the above patient _____

I **do NOT recommend** horseback riding for the above patient _____

Recommended Frequency: _____

Precautions: _____

Physician's Signature: _____ **Date:** _____

Physician's Name: _____ Phone: _____

Address of Practice: _____
