Therapeutic Horseback Riding

Physician's Referral

Name:_____DOB_____ Age_____

Address:_____City:_____State:_____

Phone:_____ Fax:_____

Diagnosis:_____

Concerns:_____

Current Medications:_____

Precautions and Contraindications:_____

Comments:_____

Recommended Frequency:_____

Physicians Name:_____

Phone:_____ Fax:_____

Address:_____City:_____State:_____

I recommend the above person undergo an evaluation by a licensed professional (OT or PT) in conjunction with the Walk On Therapeutic Horseback Riding Program. This evaluation is to determine the strength and challenges as well as appropriate horse and equipment needs of the participant.

_____ _____

Physician's Signature Date

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Barn (847) 842-8349
Fax (847) 381-4288

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