THE RIGHT STEP, INC.

THE HEALING POWER OF HORSES

A PATH Intl. Premier Therapeutic Riding Program

Date: _____

Dear Healthcare Provider:

Your patient: _____ is interested in participating in therapeutic horseback riding.

In order for us to safely provide this activity, our program requests that you complete the attached Medical History and Physician's Statement. Please note that the following conditions may suggest precautions and contraindications to therapeutic horseback riding. Therefore, when completing this form, please note whether any of 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
Spina Bifida/Chiari II Malformation Tethered Coed/Hydromyelia

Other
Age-under 4 years
Indwelling Catheters/Medical Equipment
Medications-e.g. Photosensitivity
Poor Endurance
Pregnancy
Skin Breakdowns

Medical/Psychological
Allergies
Animal Abuse
Cardiac Condition
Physical/Sexual/Emotional Abuse
Blood Pressure Control
Dangerous to Self or Others
Exacerbations of Medical Conditions
Fire Settings
Hemophilia
Medical Instability
Migraines
PVD
Respiratory Compromise
Recent Surgeries
Substance Abuse
Thought Control Disorders
Weight Control Disorders

Thank you very much for your assistance. If you have any questions or concerns regarding this patient's participation in therapeutic horseback riding, please contact me.

Sincerely,

Emily Stibbards
Program Director

9/10/19