

# PHYSICIAN PACKET



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Date: \_\_\_\_\_

Dear Health Care Provider:

Your patient, \_\_\_\_\_  
(*participant's name*)

is interested in participating in supervised equine activities.

In order to safely provide this service, our center 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  
Coxa Arthrosis  
Cranial Deficits  
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 Cord/Hydromyelia

#### **Other**

Age - under 4 years  
Indwelling Catheters/Medical Equipment  
Medications - i.e. photosensitivity  
Poor Endurance  
Skin Breakdown

#### **Medical/Psychological**

Allergies  
Animal Abuse  
Cardiac Condition  
Physical/Sexual/Emotional Abuse  
Blood Pressure Control  
Dangerous to self or others  
Exacerbations of medical conditions (i.e. RA, MS)  
Fire Settings  
Hemophilia  
Medical Instability  
Migraines  
PVD  
Respiratory Compromise  
Recent Surgeries  
Substance Abuse  
Thought Control Disorders  
Weight Control Disorder

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 the center at the address/phone indicated above.

Sincerely,

# HOPE THERAPY

1591 Big Branch Rd.  
Middleburg, FL 32068  
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OCCUPATIONAL THERAPY    ( ) PHYSICAL THERAPY    ( ) SPEECH THERAPY

## PRESCRIPTION

Child's Name \_\_\_\_\_ DOB: \_\_\_\_\_

Diagnosis: Please check one of the following. If more than one diagnosis applies, please number in order of importance.

- |  |   |
|--|---|
| <input type="checkbox"/> Hypotonia (728.9)                     | <input type="checkbox"/> Myelomeningocele lumbar region (741.93)      |
| <input type="checkbox"/> Coordination Disorder (781.3)         | <input type="checkbox"/> Cerebral Palsy: Spastic Diplegia (343.0)     |
| <input type="checkbox"/> Apraxia/ Dyspraxia (748.69)           | <input type="checkbox"/> Cerebral Palsy: Spastic Quadriplegia (343.2) |
| <input type="checkbox"/> Infantile Cerebral Palsy (343.9)      | <input type="checkbox"/> Cerebral Palsy: Spastic Hemiplegia (343.1)   |
| <input type="checkbox"/> Static Encephalopathy (349.9)         | <input type="checkbox"/> Developmental Coordination Disorder (315.4)  |
| <input type="checkbox"/> Developmental Disorder (315.9)        | <input type="checkbox"/> Infantile spinal muscular atrophy (335.0)    |
| <input type="checkbox"/> Down's Syndrome (758.0)               | <input type="checkbox"/> Closed Head Injury (854.0)                   |
| <input type="checkbox"/> Cerebellar Ataxia (334.3)             |   |
| <input type="checkbox"/> Other (specify name & ICD code) _____ |   |

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## CONTRAINDICATIONS/ PRECAUTIONS

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Therapy is prescribed for the following treatment:

- gross/fine motor coordination via neuromuscular reeducation or therapeutic activities
- gait training
- sensory integrative activities
- perceptual activities
- therapeutic exercise

Frequency

Duration

Physician's Name: \_\_\_\_\_

Address: \_\_\_\_\_

Physician's Signature \_\_\_\_\_

Date: \_\_\_\_\_ Telephone: \_\_\_\_\_

# Hope Therapy

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Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Address: \_\_\_\_\_

Name of Parent/Guardian: \_\_\_\_\_

Diagnosis: \_\_\_\_\_ Date of Onset: \_\_\_\_\_

**\*\* For Persons with Down Syndrome:**

Negative Cervical X-ray for Allantoaxial Instability. X-ray date \_\_\_\_\_

Negative for clinical symptoms of Allantoaxial Instability.

Tetanus Shot:  Yes  No Date \_\_\_\_\_ Height \_\_\_\_\_ Weight \_\_\_\_\_

Seizure Type \_\_\_\_\_ Controlled \_\_\_\_\_ Date of last seizure \_\_\_\_\_

Medications \_\_\_\_\_

Please indicate if patient has a problem and/or surgeries in any of the following areas by checking yes or no. If yes, please comment.

Area	Yes	No	Comments
Auditory			
Visual			
Speech			
Cardiac			
Circulatory			
Pulmonary			
Neurological			
Muscular			
Orthopedic			
Allergies			
Learning Disability			
Mental Impairment			
Psychological Impairment			
Other			

Mobility: Independent Ambulation  Yes  No Crutches  Yes  No Braces  Yes  No  
Wheelchair  Yes  No Please indicate any special precautions: \_\_\_\_\_

To my knowledge there is no reason why this person cannot participate in supervised equestrian activities. However, I understand that the therapeutic riding center will weigh the medical information above against the existing precautions and contraindications. I concur with a review of this person's abilities/limitations by a licensed/credentialed health professional (e.g. PT, OT, Speech, Psychologist, etc.) in the implementing of an effective equestrian program.

Physician Name (please print) \_\_\_\_\_

Physician Signature \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_