Michigan Abilities Center
7286 W. Ellsworth Road, Ann Arbor, MI 48103
Phone: (734) MAC-9500 Fax: (734) MAC-9555
Website: MichiganAbilitiesCenter.org

Dear Physician:

Your patient, ________________________ is interested in participating in supervised equestrian activities.
(participant's name)
In order to safely provide this service, our center requests that you complete the attached Medical History and Physician's Statement Form. Please note that the following conditions may suggest precautions and contraindications to therapeutic horseback riding and hippotherapy. 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 fusion /fixation
Spinal instabilities/abnormalities

Neurologic
Seizure
Hydrocephalus/shunt
Spina Bifida/Chiari II malformation/ Tetherd Cord/Hydromyelia

Other
Age-under 4 years
Indwelling Catheters
Medications - i.e. photosensitivity
Poor endurance
Skin breakdown

Medical/Psychological
Allergies
Animal Abuse
Physical/Sexual/Emotional Abuse
Blood Pressure Control
Dangerous to self or others
Exacerbations of medical conditions
Fire settings
Heart Conditions
Hemophilia
Medical Instability
Migraines
PVD
Respiratory Compromise
Recent Surgeries
Thought Control Disorder
Weight Control Disorder
Substance Abuse

Thank you very much for your assistance. If you have any questions or concerns regarding this patient's participation in therapeutic equine activities, please feel free to contact the center at the address/phone indicated above.

Sincerely,
Kathleen A. Hinderer, PhD, MPT, PT
Executive Director
Michigan Abilities Center

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Medical History & Physician's Statement

Name ____ DOB ___________ Weight ___________ Height _________
Diagnosis ____ Date of Onset _____________
Past/Prospective Surgeries: ____
Medications ____
For those with Down Syndrome*:* AtlantoDens Interval X-rays, date: ____________________________ Result: + --
Neurologic Symptoms of AtlantoAxial Instability: ____
Seizure Type ____________________________________ Controlled: Y N Date of last seizure ________________
Shunt present: Y N Date of last revision: ____
Special precautions/needs: ____
Mobility: Independent Ambulation: Y N Assisted Ambulation Y N Wheelchair: Y N
Braces/Assistive Devices: ____

Please indicate current or past difficulties in the following systems/area, including surgeries:

	Y	N	Comments
Auditory			
Vision			
Sensation			
Coordination			
Balance (sit &/or stand)			
Communication/Speech			
Activities of Daily Living			
Cardiac			
Circulatory			
Pulmonary			
Gastrointestinal			
Integumentary/Skin			
Immunity			
Neurologic			
Muscular			
Orthopedic			
Pain			
Allergies			
Learning Disability			
Cognitive			
Emotional/Psychological			
Behavior			
Other			

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 refer this person with the understanding of ongoing evaluation to determine eligibility for participation. 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 implementations of an effective equestrian program.

Printed Name & Title: ____ MD DO Other _________Date: _______________
Signature: ____ Phone: ______________________________
Address: ____ License/UPIN Number: ____________________