Rainbow Riders - Therapeutic Riding Newfoundland and Labrador Inc.
P.O. Box 23199
St. John's, NL A1B 4J9
rainbowridersnl@gmail.com

PHYSICIAN REFERRAL FORM

ATTENTION: It is important that this form be filled out in detail (e.g. height, weight etc) in order for the instructor and physiotherapist to match the rider with the mount.

RIDER INFORMATION

Name: _____ MCP#:_____

Address:_____ Date of Birth:_____

Phone (Home):_____ (Work): _____ (Cell): _____

Next of Kin/Guardian:_____

Living at home:_____ Other:_____

MEDICAL

Primary Diagnosis:_____

Secondary Diagnosis:_____

Height:_____ Weight:_____ Sex:_____

Diabetic:_____ Insulin: _____ Epileptic:_____

If epileptic, frequency of seizures:_____ Date of last seizure:_____

Medications:_____

For_____

Communicable disease: Yes _____ No _____

If yes, explain: _____

_____

_____

SUGURY	DATES

Ambulatory: Yes_____ No_____

If yes, specify: _____

_____

Muscle Tone (spasticity, flaccidity, etc.):_____

Tone in upper extremities: _____

_____

Tone in lower extremities:_____

_____

Range of motion in lower extremities:_____

Tone in trunk:_____

Balance: Sitting:_____ Standing: _____ Walking: _____

Language: English_____ Sign Language: _____ Other:_____

Speech: Good: _____ Fair: _____ Poor: _____

Ability to Understand: Good: _____ Fair: _____ Poor:_____

Sensory Function: Sight: _____Hearing: _____ Tactile_____

Continence:_____

Allergies:_____

Other possible precautions_____

_____

I hereby give permission for the above individual to participate in the riding program at **Rainbow Riders – Therapeutic Riding Newfoundland and Labrador Inc.**

Physician's name:_____

Physician's signature: _____ Date: _____

Physician's Address:_____

Telephone: _____ Fax:_____

Therapist Consult: Any recommendations, precautions or limitations:

_____

_____

_____

_____

_____

_____

Therapist:_____Date:_____