



Cowichan Therapeutic Riding Association

1843 Tzouhalem Road, Duncan, BC, V9L 5L6

Phone: 250 746 1028, Fax: 250 746 1033, email: colleen@ctra.ca or info@ctra.ca

PHYSICIAN'S REFERRAL

Name: _____ Date: _____

Date of Birth: _____ Occupation/Student: _____

Next of Kin/Guardian: _____

Living at Home: _____ Other: _____

Medical Information

Primary Diagnosis: _____

Secondary Diagnosis: _____

Height: _____ Weight: _____ Sex: M _____ F _____

Diabetic: _____ Insulin: _____ Epileptic: _____

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

Medications: _____

For: _____

Communicable disease: Yes _____ No _____ if yes, explain: _____

Surgery: _____ **Date:** _____

Ambulatory: Yes _____ No _____ If yes, specify: _____

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

Tone in upper extremities: _____

Tone 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: _____

Contenance: _____

Allergies: _____

When do you recommend this patient to reassessed? _____

I hereby give my permission for the above individual to participate in the Cowichan Therapeutic Riding program at Providence Farm.

Physician's
Signature: _____ Date: _____

Physician's
Name: _____ Date: _____
(please print clearly)

Physician's
Address: _____ Date: _____
(please print clearly)

Telephone: _____ Fax: _____

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

A list of contraindications and precautions to therapeutic riding is enclosed for your information.

Med Forms.08

EXTENDED PHYSICIAN'S REFERRAL

To: Cowichan Therapeutic Riding Association

Re: _____

The last medical referral submitted on _____ is still valid.

There have been no significant changes to the condition of the client other than as noted below.

Date: _____ Signature: _____

Printed Name: _____