Date:_____

Dear Physician:

Your patient,_____ (participant's name) is

___Interested in participating in our program

___Interested in continuing to participate in our program

In order to safely provide this service, our program requests that you complete/update the attached Medical History and Physician's Statement form. Please note that the following conditions may suggest precautions or contraindications to our program. 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 Instability/Abnormalities

NEUROLOGIC
Hydrocephalus/Shunt
Seizure
Spina Bifida/Chiari II malformation/Tethered Cord/Hydromyelia

OTHER

Age - under 4 year
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 Setting
Heart conditions
Hemophilia
Medical Instability
Migraines
Peripheral Vascular Disease
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 our program(s), please feel free to contact Hochoka at the address and phone number indicated below.

Sincerely,

Kimberly Clarke

HOCHOKA
Retreat Center

Healing by the Way of the Horse

PO Box 6345
Hickory NC 28603
(704) 651-4800
www.healingwithhorses.com

PARTICIPANT'S MEDICAL HISTORY AND PHYSICIAN'S STATEMENT

Name: _____Date of Birth: _____ Height: _____Weight: _____
Address: _____
Diagnosis:_____
_____
Past/Prospective Surgeries: _____
Medications: _____
Seizure Type: _____ Controlled?: Yes No Date of last seizure:_____
Shunt present?: Yes No Date of last revision(s): _____ Date of last Tetanus Shot_____
Special Precuations/Needs:_____
_____
Mobility: Independent Ambulation? Yes No Assisted Ambulation? Yes No Wheelchair? Yes No
Braces/Assistive Devices: _____

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

	Yes	No	Comments
Auditory			
Visual			
Tactile Sensation			
Speech			
Cardiac			
Circulatory			
Integumentary/Skin			
Immunity			
Pulmonary			
Neurologic			
Muscular			
Balance			
Orthopedic			
Allergies			
Learning Disability			
Cognitive			
Emotional/Psychological			
Pain			
Other			

To my knowledge there is no reason why this person cannot participate in supervised equestrian activities. However, I understand that Hochoka will weigh the medical information above against the existing precautions and contraindications.1 concur with a review of this person's abilities/limitations by a licensed/credentialed health professional (e.g. PT, OT, Speech language Pathologist, Psychologist, etc.) in the implementation of an effective equestrian program.

Name/Title: _____MD DO NP PA Other:_____
Signature: _____ Date:_____
Address: _____ City_____ State_____ Zip _____
Phone: (____)_____

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PARTICIPANT'S CONSENT FOR RELEASE OF INFORMATION

I hereby authorize: _____ (Facility/ Person)

To release information from the records of :_____(Participant Name) whose Date of Birth is: _____.

The information is to be released to: Kimberly Clarke, for the purpose of developing a proper program level for the above named participant. The information to be released is marked below:

___ Medical History

___ Occupational Therapy evaluation, assessment and program plan

___ Speech Therapy evaluation, assessment and program plan

___ Physical Therapy evaluation, assessment and program plan

___ Psychosocial Evaluation, assessment and program plan

___ Cognitive-Behavioral Management Plan

Other: _____

Hochoka agrees to maintain all information received in compliance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and the Family Educational Rights and Privacy Act (FERPA).

Date: _____ Signature :_____(participant, parent, or guardian)

Please send materials to:

Hochoka
PO Box 6345
Hickory NC 28603

Please use the space to provide any additional information or experience you would like to provide that will help the Hochoka team best serve you / your child's needs:

_____
_____
_____
_____

If services are for your child, does your child have siblings? If so, have they ever been around or on a horse/pony? Please describe.

_____
_____
_____

Medication (include prescription, over the counter, name, dose, and frequency):

_____
_____
_____

Describe participant's abilities/ difficulties in the following areas (include assistance required or equipment needed).

PHYSICAL FUNCTION (ie Mobility skills such as transfers, walking, wheelchair use, driving):

_____
_____
_____
_____

PSYCHOSOCIAL FUNCTION (ie Work/ school, leisure interests, support systems, family relationships, companion animals, fears/ concerns/aspirations, etc):

_____
_____
_____

COMMUNICATION FUNCTION (ie verbal, non-verbal, gestural, picture/symbols – Methods used for current communication, etc.):

_____
_____
_____

GOALS (ie Why did you apply for participation? What would you like to accomplish?):

_____
_____
_____
_____