

**Physician's Statement**

To be completed by the referring physician  
 This is a 2 page document  
 Both sides must be completed and signed

**RCTRC, INC.**  
**Administrative Offices and Facilities:**  
 RR 3 Box 397  
 Milton, WV 25541  
 (304) 743-5267  
<http://rctrc.org>

**GENERAL MEDICAL INFORMATION**

Client's Name:(Last, First, M.I.)		<input type="checkbox"/> M <input type="checkbox"/> F	DOB: ____/____/____ Age: _____ Height: _____ Weight: _____
Address:			
City, State and Zip Code:			
E-mail Address:		Phone:	Alternative #:
Diagnosis(es):			Onset Date:
Seizures: <input type="checkbox"/> Yes <input type="checkbox"/> No Type:		Controlled: <input type="checkbox"/> Yes <input type="checkbox"/> No	Date of Last Seizure:
Shunt Present: <input type="checkbox"/> Yes <input type="checkbox"/> No		Date of Last Shunt Revision:	
Special Precautions/Needs:		Assistive Devices:	
<b>Mobility:</b> Independent Ambulation <input type="checkbox"/> Yes <input type="checkbox"/> No		Assisted Ambulation: <input type="checkbox"/> Yes <input type="checkbox"/> No	Wheelchair: <input type="checkbox"/> Yes <input type="checkbox"/> No

**Precautions/Limitations/Concerns**

	Yes	No	Comments
Auditory	<input type="checkbox"/>	<input type="checkbox"/>	
Visual	<input type="checkbox"/>	<input type="checkbox"/>	
Tactile Sensation	<input type="checkbox"/>	<input type="checkbox"/>	
Speech	<input type="checkbox"/>	<input type="checkbox"/>	
Cardiac	<input type="checkbox"/>	<input type="checkbox"/>	
Circulatory	<input type="checkbox"/>	<input type="checkbox"/>	
Integumentary/Skin	<input type="checkbox"/>	<input type="checkbox"/>	
Immunity	<input type="checkbox"/>	<input type="checkbox"/>	
Pulmonary	<input type="checkbox"/>	<input type="checkbox"/>	
Neurologic	<input type="checkbox"/>	<input type="checkbox"/>	
Muscular	<input type="checkbox"/>	<input type="checkbox"/>	
Balance	<input type="checkbox"/>	<input type="checkbox"/>	
Orthopedic	<input type="checkbox"/>	<input type="checkbox"/>	
Allergies	<input type="checkbox"/>	<input type="checkbox"/>	
Learning Disabilities	<input type="checkbox"/>	<input type="checkbox"/>	
Cognitive	<input type="checkbox"/>	<input type="checkbox"/>	
Emotional/Psychological	<input type="checkbox"/>	<input type="checkbox"/>	
Pain	<input type="checkbox"/>	<input type="checkbox"/>	
Other	<input type="checkbox"/>	<input type="checkbox"/>	

**For those with Down Syndrome:** Atlanto-Axial X-Rays, Date: \_\_\_\_\_ Result Positive Negative

Neurologic Symptoms of Atlanto-Axial Instability:

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CONSENT PLAN	
To my knowledge, there is no reason why this person cannot participate in supervised therapy, recreational, and/or play activities (may include equestrian, aquatic, horticulture activities). However, I understand that RCTRC, Inc. will weigh the medical information above against the existing precautions and contraindications.	
Physician's Name:	MD, DO, NP, PA Other:
License/UPIN Number:	Phone:
Address	
Signature:	

In order to safely provide therapy and recreation based programs, RCTRC requests that when you complete this document, please note that the following conditions may suggest precautions and contraindications to fully participate in our programs. Therefore, when completing this form, **please note whether these conditions are present, and to what degree** on the **front** of this document.

### Orthopedic

- Atlanto-Axial Instability – include neurologic symptoms
- Coxa Arthrosis
- Cranial Deficits
- Heterotrophic 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 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
- Arson/Fire settings
- Heart conditions
- Hemophilia
- Medical instability
- Migraines
- PVD
- Respiratory Compromise
- Recent Surgeries
- Thought Control Disorders
- Weight control disorder

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

Connie Boggess, MS, CTRS, OTR/L  
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