Grace Lake Ministries
Horses, Hope & Healing.

Dear Health Care Provider:

Your patient, _____, is interested in participating in supervised Equine Assisted Services.

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 equine activities. Therefore, when completing the attached form, please note whether these conditions are present, and to what degree.

Orthopedic

Atlantoaxial Instability – include neurologic symptoms
Coxarthrosis
Cranial Defects Heterotopic
Heterotopic Ossification/Myositis Ossificans
Joint subluxation/dislocation
Osteoporosis
Pathologic Fractures
Spinal Joint Fusion/Fixation
Spinal Joint Instability/Abnormalities

Neurologic

Hydrocephalus/Shunt
Seizure
Spina Bifida/Chiari II Malformation/Tethered Coed/Hydromyelia

Other

Age – under 4 years
Indwelling Catheters/Medical Equipment
Medications – e.g., Photosensitivity
Poor Endurance
Skin Breakdown

Medical/Psychological

Allergies
Animal Abuse
Cardiac Condition
Physical/Sexual/Emotional Abuse
Blood Pressure Control
Dangerous to Self or Others
Exacerbations of Medical Conditions (e.g., RA, MS)
Fire Setting
Hemophilia
Medical Instability
Migraines
PVD
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 Equine Assisted Services, please feel free to contact the center at the address/phone indicated below.

Sincerely,

Holly Robinson, Director
director@gracelakeministries.org

Participant's Medical History & Physician's Statement

Participant: _____ DOB: _____ Height: _____ Weight: _____

Address: _____

Diagnosis: _____ Date of Onset: _____

Past/Prospective Surgeries: _____

Medications: _____

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: _____

For those with Down syndrome: Neurologic Symptoms of Atlantoaxial Instability: ☐ Present ☐ Absent

Please indicate current or past special needs in the following systems/areas, including surgeries: These conditions may suggest precautions and contraindications to equine activities.

	Y	N	Comments
Auditory			
Visual			
Tactile Sensation			
Speech			
Cardiac			
Circulatory			
Integumentary/Skin			
Immunity			
Pulmonary			
Neurologic			
Muscular			
Balance			
Orthopedic			
Allergies			
Learning Disability			
Cognitive			
Emotional/Psychological			
Pain			
Other			

Given the above diagnosis and medical information, this person is not medically precluded from participation in Equine Assisted Services. I understand that Grace Lake Ministries will weigh the medical information given against the existing precautions and contraindications. Therefore, I refer this person to the Grace Lake Ministries for ongoing evaluation to determine eligibility for participation.

Name/Title: _____ MD DO NP PA Other _____

Signature: _____ Date: _____

Address: _____

Phone: _____ License/UPIN Number: _____