Date:

Dear Health Care Provider:

Your patient

*(participant’s name)*

is interested in participating in supervised equine activities.

In order to safely provide this service, our center requests that you complete/update 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 this form, please note whether these conditions are present, and to what degree.

**Orthopedic**

Atlantoaxial Instability - include neurologic symptoms

Coxarthrosis

Cranial Defects

Heterotopic Ossification/Myositis Ossificans

Joint subluxation/dislocation

Osteoporosis

Pathologic Fractures

Spinal Joint Fusion/Fixation

Spinal Joint Instability/Abnormalities

**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

**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

Thank you very much for your assistance. If you have any questions or concerns regarding this patient’s participation in

equine-assisted activities, please feel free to contact the center at the address/phone indicated above.

Sincerely,

*Name*

*Center Name*

*Phone Number*

PATH Intl. Standards for Certification & Accreditation

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This is an initial letter to your participant’s physician. Attach the Participant’s Medical

History & Physician’s Statement.