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**Equine-Facilitated Psychotherapy**

**Referral Form**

Client Name: DOB: Age:

Address: Phone:

Diagnosis:

Recommended Frequency and Duration of Sessions:

Type of Format:

Specific issues to address:

Group Work

Individual Work

Family Work

Current treatment goals:

Additional information:

Mental Health Professional

Date

State Credentials/License #

Phone & Fax Numbers

Address

Return to: (riding program’s name & address)

Thank You for Your Participation and Referral

**PATH Intl. Standards for Certification & Accreditation**

**2018**