PATH
INTERNATIONAL
Professional Association of Therapeutic Horsemanship International

Medical Record Maintenance Compliance Form

I certify that I maintain the following records for each participant I treat at

_____

(center name)

1. A prescription from a physician IF required by my practice act or local laws and regulations
2. A comprehensive written initial assessment including screening for precautions and contraindications
3. A written treatment plan that includes long- and short-term goals reflective of the type of therapy
4. Written progress notes, completed on a regular basis, that reflect the treatment and its modifications based on the response of the patient
5. Written periodic review, and re-evaluations completed on a regular basis that update the goals and treatment plan and make recommendations for further treatment, discharge or transition into another program

_____

Printed Health Professional Name and Credentials

_____

Health Professional Signature/Date

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Equine-Facilitated Psychotherapy

Consent for Release of Confidential Information

I, _____, hereby authorize and request that
(client)

_____ may release to
(mental health professional)

_____
(center name)

the following information (please check the allowable information):

- ❑ Admission for Treatment
- ❑ Diagnosis
- ❑ Psychiatric Evalution
- ❑ Psychological Testing Results
- ❑ Treatment Progress Notes
- ❑ Discharge Summary
- ❑ Physician Orders
- ❑ Other _____

The purpose of this disclosure is for the development of an equine-facilitated psychotherapeutic plan and program. I understand that this authorization will remain in effect until _____ (specify date, which is not to exceed 12 months).

This information will be released in the following format (verbal per telephone, electronic, mail, hand-carried): _____

Pursuant to Federal Regulations, this information will not be forwarded to any other provider or agent.

_____ _____
Client Date

_____ _____
Parent or Legal Guardian Date

_____ _____
Witness Date

_____ _____
Referring Mental Health Professional Date

_____
Address of Mental Health Professional

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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: ___ Group Work ___ Individual Work _____ Family Work

Specific issues to address:

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

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Mental Health Data Form

Client's Name: _____

Age: _____ DOB: _____ Sex: _____ Height: _____ Weight: _____

Parent/Legal Guardian: _____ Phone: H _____ W _____

Address: _____

Physician: _____ Phone: _____

Mental Health Professional: _____ Phone: _____

Diagnosis (DSM-IV)

Axis I _____

Axis II _____

Axis III _____

Axis IV _____

Axis V _____

Presenting Problems

_____

_____

_____

_____

_____

_____

Current Medications

Drug	Dose	Route	Time	Purpose

Psychiatric Treatment History

Current Therapy	Where	When	Diagnosis
Outpatient Therapy			
Inpatient Therapy			

Therapeutic and Safety Issues

Check and describe applicable issues (indicate current history of):

- ❑ inattention
- ❑ hyperactivity
- ❑ lack of concentration
- ❑ learning disabilities
- ❑ developmentally delayed
- ❑ cognitively challenged
- ❑ boundary issues
- ❑ social skills problems
- ❑ problems with peers
- ❑ separation anxiety
- ❑ anxiety
- ❑ phobias
- ❑ aggressive
- ❑ assaultive
- ❑ manipulative
- ❑ unpredicatable or dangerous behavior
- ❑ sensory impairment
- ❑ sensitivity, preferences
- ❑ tics or stereotypic behavior
- ❑ psychosomatic symptoms
- ❑ medical issues
- ❑ self-injurious behavior
- ❑ suicidal ideations
- ❑ history of runaway
- ❑ issues of parental support
- ❑ issues of family support
- ❑ sexual abuse/acting out
- ❑ history of physical abuse
- ❑ emotional abuse
- ❑ hallucinations
- ❑ delusions
- ❑ illusions
- ❑ dissociations
- ❑ substance abuse problems
- ❑ legal problems
- ❑ school problems
- ❑ history of animal abuse and/or ❑ fire setting
- ❑ seizure disorder
- ❑ possible medication side effects

Information Source Date Form Completed

Ideally this form is designed to be used in conjunction with the PATH Intl. Participant Medical History, Physician's Statement and Physician's Release Statement.

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FOR PROVIDER OF THERAPY SERVICES

Consent for Treatment and Release of Liability

Mental Health Professional Name or Business Name

Address and Phone Number

**This is not a complete form and may not be photocopied. Each provider of therapy services must create their own form after obtaining legal counsel in order to include appropriate wording and content for particular state regulation and different treatment situations.*

Samples of wording that may be included:

> "No child can be accepted for therapy until all forms have been completed by the parent/guardian. If the patient is of legal age and mentally competent, he/she may complete the forms without parent's or guardian's signature."

> "Although every effort will be made to avoid accident or injury, NO LIABILITY can be accepted by any of the organizations concerned, including (*name of center or therapy practice/provider*), its officers, trustees, agents, employees, each and every one of its members and associates, and the property owners upon whose land the therapy sessions are conducted."

> "I request and consent to treatment that may include therapy, and I have discussed this with my child's doctor. I understand that no liability can be accepted by any of the organizations concerned with this therapy, including (*name of center or therapy practice/provider*)."

Dated signatures of parent/guardian or client of legal age must be included.