PARDS
THERAPEUTIC CENTRE

ALL SECTIONS BELOW TO BE COMPLETED BY PHYSICIAN

Client's Name: M___ F___	Birthday: (M/D/Y)
Primary Disability/Diagnosis:	Date of Onset:
Secondary Disability/Diagnosis:	Date of Onset:

Please indicate if client has had a problem and/or surgeries in any of the following areas by checking yes or no. If yes, please comment, or circle (if applicable).

Height: _____	Weight: _____

Area	Yes	No	Comment
Epileptic:			Type: _____ Last Seizure: _____ Frequency: _____ Controlled: Yes or No
Down Syndrome			Cervical X-ray for Atlantoaxial Instability: positive or negative Date of X-ray:
Diabetic			Insulin:
Communicable Disease			
Hearing Impairment			
Speech Impairment			
Vision Impairment			
Mental Impairment			
Learning Disability			
Muscular Weakness			
Coordination Problems			
Circulatory Problems			
Cardiac Problems			
Pulmonary Problems			
Orthopedic Problems			Scoliosis: degree of:
Chronic Pain			
Brittle Bones			
Reduced Stamina			
Spasticity			
Allergies			
Medication(s)			
Mobility Aids			Prosthesis / Leg Brace / Wheelchair / Wrist Brace / Hearing Aid / Crutch / Walker / Other:
Appliances			(ex. Harrington Rod)

Special Precautions: *In my opinion, this patient can participate in supervised equestrian activities. In conjunction with these activities, I concur in the referral of the patient to a physical/occupational therapist or other health care professional for evaluation of abilities/limitations in performing exercises and implementing an effective equestrian program.*

Medical Review Recommended in: 1 yr____ 2 yrs ____ 5 yrs ____ other_____

Physician Name/Stamp:_____Physician Signature: _____

Address:_____Phone:_____Date:_____