

# HORSES *for* HOPE

TRC, Inc.



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 the **Participant's Medical History & Physician's Statement** 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

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

Sincerely,

Gwen Roberts

Horses for Hope TRC, Inc.

919-270-4832

Name

Center Name

Phone Number