



P. O. Box 376 Barrington, IL 60011- 0376 Office: (847) 381-4231 Fax: (847) 381-4288

**Therapeutic Horseback Riding Program
Physician's Referral**

Participant Name: _____ DOB: _____ Age: _____

Address: _____

Home Phone: _____ Cell: _____

Diagnosis: _____

Concerns: _____

Current Medications: _____

Precautions and Contraindications: _____

Comments: _____

Recommended Frequency (Weekly): _____

Physician's Name: *(Please Print)*: _____

Address: _____

I recommend the above person to undergo an Evaluation by a licensed professional (OT or PT) in conjunction with the Walk On, Equine Assisted Program (*Therapeutic Horseback Riding*). This evaluation is to determine the strengths and challenges as well as appropriate horse and equipment needs of the specific participant.

Physician's Signature

Date