## **Stepping Stones Therapeutic Riding, Inc.** PHYSICIAN'S REFERRAL

	Date
	County:
Name:	Date of Birth:
Address:	Height:
Parent/Guardian:	Weight:
The Stepping Stones Therapeutic Riding, Inc. is a triders physically, socially, and emotionally. The inc Riding for the Handicapped Association (NARHA) volunteers are used in each program in order to e personal benefit from the program, every rider is requested being accepted as a riding student. Diagnosis:	structors are certified through the North American b. Safety equipment, specially trained horses, and ensure the fullest possible protection and greatest quired to furnish the following medical information
If diagnosis is Down's Syndrome, this form must be a	accompanied by one of the following
<ol> <li>Stepping Stones Therapeutic Riding, Inc. Down's Syndrome Rider Evaluation.</li> <li>Michigan Special Olympics Down Syndrome Athlete Evaluation.</li> <li>A signed, dated statement from a qualified physician giving the date and result of a diagnostic x-ray for Atlanto-Axial Dislocation Condition.</li> <li>Note: Because of the nature of the activity of horseback riding, no individual diagnosed as having Down's Syndrome can be accepted for riding instruction without proof of a negative diagnostic x-ray or Atlanto-Axial Dislocation Condition.</li> <li>Medical history:</li> </ol>	
Surgical procedures:  Medications:	
Defects present in: ( ) sight ( ) neurosensation ( ) musc	( ) hearing ( ) speech ( ) mobility cle tone ( ) balance ( ) coordination
	( ) no ( ) yes ( ) crutches ( ) wheelchair ( ) other
Comment if applicable:	
Seizures:	
Incontinence:	
General comments:	
In my opinion, the patient named can receive riding in	
Physician's signature:	Date:
Address:	Date: Phone:

Note: The Down's Syndrome form may be added to the back of this form if it is clearly so marked.