



Valley Therapeutic Equestrian Association
 3330 256th St, Langley, BC, V4W 1Y4
 Phone: 604-857-1267 Fax: 604-625-1268
 Email: info@vtea.ca Website: www.vtea.ca

Physician Referral Form

Name of Client: _____ Date of Birth: _____

Weight (lbs): _____ Height (ft/in): _____

Diagnosis/Disability: _____

Date of Onset: _____

How often should this form be updated/reviewed: _____

(if not specified, VTEA policy is every 2 years)

IMPAIRMENT(S):	YES/NO ABNORMAL/NORMAL	COMMENTS:
Auditory Impairments	_____	_____
Speech Impairments	_____	_____
Visual Impairments	_____	_____
Circulatory Impairments	_____	_____
Sensation	_____	_____
Incontinence – Bladder	_____	_____
Incontinence – Bowel	_____	_____
Assistive Devices	_____	_____
Psychological or	_____	_____
Behaviour Concerns	_____	_____
Spinal/Joint Abnormalities	_____	_____
Hip Subluxation or	_____	_____
Dislocation	_____	_____
Co-ordination in Lower	_____	_____
Extremities:	_____	_____
Muscle Tone – Arms:	_____	_____
Muscle Tone – Legs:	_____	_____
Muscle Tone – Trunk/Legs	_____	_____
Balance – static sitting	_____	_____
Balance – dynamic sitting	_____	_____

Seizures (grand/petit/date) _____

Medication(s) please list _____

Medication(s) Side Effects _____

Relevant Surgeries/Date(s) _____

Tetanus Vaccine/Date _____

Communicable Diseases _____

Allergies _____

Down Syndrome &
Rheumatoid Cervical Spine
X-rays (sub-occipital &
Atlanto/Axial Joints (Year) _____

Flexion/Extension _____

X-rays Required (Year) _____

Please note that if a Client has Down Syndrome, an x-ray clearing him/her of Atlanto-Axial Instability must be taken and confirmed in letter form along with this referral form.

Precautions (if yes – please indicate): _____

Please note: there is a weight limit of 180 pounds for clients at VTEA (with riding attire on).

Comments: _____

In my opinion, this patient can receive therapeutic riding lessons under proper instruction. I understand that this patient may receive assessment/treatment by a physiotherapist, occupational therapist or psychologist in conjunction with this therapeutic riding program regarding his/her physical and/or behavioral abilities/limitations in performing with the program.

Physician's Name: _____ Phone # _____

Physician's Signature: _____ Date Form Completed: _____