



Rivers Edge Camp Equestrian Centre
P.O. Box 39, Cremona, AB, Canada T0M 0R0
403-637-2766 (office) 403-637-2765 (fax)
www.riversedgencamp.org

Dear Doctor:

Thank you for completing the referral form for your patient to ride at Rivers Edge Equestrian Centre Therapeutic Riding Program. Your comments will greatly help our therapists and instructors provide a better quality riding program for the applicant. Where possible, please be specific with your comments.

Included in this packet are:

1. A list of contraindication and precautions.
2. A physician referral form.

Please take some time to review the list of contraindications and precautions, and consider the ones that may be applicable for your patient. If you have any questions or concerns, contact our office. As well, please review the list of conditions that require a cervical spine and/or flexion-extension X-ray. If an X-ray is indicated, please attach a copy of the results of the X-ray report to this referral.

Upon receiving your referral and other documentation from the applicant, he/she will be booked for an assessment. This evaluation will assess the rider's abilities and further determine the appropriateness for the riding program. The assessment will also determine special requirements or adaptations needed for riding.

Horseback riding is considered a risk sport. Special care has been taken to manage the risks (training and selection of horses, provision of safe riding environment, training of volunteers), but all risk cannot be removed. Instructors are certified by the Canadian Therapeutic Riding Association. They have received extensive training on coaching riding classes and safety procedures, and have received basic training on disabilities. Instructors are also required to participate in continuing education sessions.

Riders may participate in private or group lessons lasting from 30-60 minutes. Depending on the level of ability of the rider, he/she may have a volunteer lead the horse, and may have one or two volunteers walk beside the horse to help provide support for the rider. Most of the classes are walk-trot, or walk only.

Thank you again for completing the referral form. If you have any questions or concerns about your patient's participation in the program, or have any other questions about Rivers Edge Camp Equestrian Centre or therapeutic riding in general, please do not hesitate to call our office at 403-637-2766.

Sincerely,

Joy Jenson
Rivers Edge Camp Equestrian Program Coordinator
CanTRA certified instructor
equine@riversedgencamp.org



GUIDELINES FOR PHYSICIANS/THERAPISTS

CONTRAINDICATIONS AND PRECAUTIONS FOR THERAPEUTIC RIDING

The following conditions may represent precautions or contraindications to therapeutic horseback riding if present in potential students. Therefore, when completing the physician's referral, please note whether these conditions are present and to what degree.

ABSOLUTE CONTRAINDICATIONS

ORTHOPEDIC:

- Acute arthritis
- Acute herniated or prolapsed disc
- Atlanto-axial instabilities
- Coxa athrosis (degeneration of hip joint)
- Structural cranial deficits
- Osteogenesis imperfecta
- Pathological fractures
- Spondylothesis
- Structural scoliosis >30 degrees, excessive kyphosis or lordosis or hemivertebra
- Spinal stenosis

NEUROLOGICAL:

- CVA 2nd to unclipped aneurysm or angioma
- Paralysis due to spinal cord injury above T6 (adult)
- Spina bifida associations – Chiari II Malformation, Hydromyelia, Tethered Cord
- Uncontrolled (grand mal) seizures within last 6 months

MEDICAL/PSYCHOLOGICAL:

- Obesity >160 lbs
- Anticoagulants

OTHER:

- Age under 2 years old
- Any condition that the instructor, therapist, physician or program does not feel comfortable treating

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GUIDELINES FOR PHYSICIANS/THERAPISTS
(continued)

RELATIVE CONTRAINDICATIONS AND PRECAUTIONS

ORTHOPEDIC:

- Arthrogyrosis
- Heterotrophic ossification
- Hip subluxation, dislocation or dysphasia
- Osteoporosis
- Spinal fusion/fixation, Harrington Rods (within 2 years of surgery)
- Spinal instabilities/abnormalities
- Spinal orthoses

NEUROLOGIC:

- Neuromuscular disorders: Amyotrophic Lateral Sclerosis, Fibromyalgia, Gullian Barre, exacerbation of Multiple Sclerosis, Post Polio Syndrome
- Hydrocephalic shunt

MEDICAL/PSYCHOSOCIAL:

- Abusive or disruptive behaviour
- Cancer
- Hemophilia
- History of skin breakdown or skin grafts
- Abnormal fatigue
- Incontinence (must wear protection)
- Peripheral vascular disease
- Sensory deficits
- Serious heart condition or hypertension
- Significant allergies
- Surgery within the last three months
- Uncontrolled diabetes
- Indwelling catheter
- Substance abuse

FLEXION/EXTENSION X-RAY REQUIRED FOR ATRAUMATIC FACTORS THAT MAY BE ASSOCIATED WITH AN UNSTABLE UPPER CERVICAL SPINE:

- | | |
|---|---|
| • Os odontoidum | • Congenital atlanto-occipital instability |
| • Down syndrome | • Klippel-Feil syndrome |
| • Athetoid cerebral palsy | • Chiari malformation with condylar hydroplasia |
| • Rheumatoid arthritis of cervical vertebrae | • Fusion of C2-C3 |
| • Congenital torticollis | • Lateral mass degeneration change at C1-C2 |
| • Sprengel deformity | • Systemic lupus |
| • Ankylosing Spondylitis | • Morquio disease |
| • Congenital chondrodysplasia | • Non-rheumatoid cranial settling |
| • Subluxation of upper cervical vertebrae due to tumors or infections | • Marshall-Smith syndrome |
| • Idiopathic laxity of the ligaments | • Diffuse idiopathic hyperostosis |
| • Grisel's syndrome | |



PHYSICIAN'S REFERRAL

NAME OF RIDER		PHONE	
ADDRESS		CITY/POSTAL CODE	
AGE	DATE OF BIRTH	WEIGHT	HEIGHT
DIAGNOSIS		DATE OF ONSET	

RIDER'S PARENT/GUARDIAN/CONTACT NAME	PHONE
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PLEASE BE SPECIFIC WHEN COMMENTING ON IMPAIRMENTS

AUDITORY IMPAIRMENTS	No	Yes		
SPEECH IMPAIRMENTS	No	Yes		
ORAL MOTOR FUNCTION	Normal	Abnormal		
VISUAL IMPAIRMENTS	No	Yes		
PSYCHOLOGICAL OR BEHAVIOURAL CONCERNS	No	Yes		
CIRCULATORY IMPAIRMENTS	No	Yes		
SENSATION	Yes	No (where)		
INCONTINENCE	BOWEL	No	Yes	
	BLADDER	No	Yes	
SPINAL/JOINT ABNORMALITIES	No	Yes		
HIP SUBLUXATION OR DISLOCATION	No	Yes		
CO-ORDINATION IN UPPER EXTREMITY	Normal	Abnormal	Grossly Abnormal	
CO-ORDINATION IN LOWER EXTREMITY	Normal	Abnormal	Grossly Abnormal	
MUSCLE TONE	ARMS	Normal	High Tone	Low Tone
	LEGS	Normal	High Tone	Low Tone
	TRUNK AND NECK	Normal	High Tone	Low Tone
BALANCE	STATIC SITTING	Good	Fair	Poor
	DYNAMIC SITTING	Good	Fair	Poor
BALANCE	STATIC	Good	Fair	Poor



	STANDING			
	DYNAMIC STANDING	Good	Fair	Poor
SEIZURES (see list of contraindications)		None	Petit Mal	Grand Mal
		Date of last Seizure		
Pre-seizure Indicators				
MEDICATION	None	Yes (please specify)		
MEDICATION SIDE- EFFECTS	None	Yes (please state)		
RELEVANT SURGERIES AND DATE				
DATE - LAST TETANUS VACCINATION				
ALLERGIES				
ASSISTIVE DEVICES OR BRACES	None	Yes (please state)		
DOWN SYNDROME & RHEUMATOID CERVICAL SPINE X-RAYS (SUB OCCIPITAL & ATLANTO/AXIAL JOINTS)* (see list of contraindications)			YEAR	
FLEXION/EXTENSION X-RAYS REQUIRED* (see following list)			YEAR	

***When applicable, please include copy of cervical spine or flexion/extension X-ray report**

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

Do you wish to see this patient regularly while he/she attends the riding program?	Yearly	2 Years	As indicated	
Precautions:	None	Yes (please state)		
How often should this form be updated?	Yearly	2 Years	5 Years	Never
COMMENTS:				

DR.'s STAMP - name/address/phone (required)	SIGNATURE
	DATE