Physician Referral

Sudbury Therapeutic Riding Program (STRP) 2022
Mailing Address: PO Box 2212
Station A, Sudbury Ont.
P3A 4S1
Phone: (705) 560-7877 Website: www.strp.ca

Patient Name: ______________________ DOB ______________ HC# ______________ M ☐ F ☐

Last First dd mm yyyy

Weight:__________ (lbs) Height: ________ (ft)

Address: ______________________ ______________ ______________ ______________

\# Street / # Apt City Postal Code Phone Number

Date: Language Preferred: Next of Kin/Guardian: ______________

Individual Living	independent with parents/guardian Other: ______________
Diagnosis	Primary: ______________ Date of onset: ______________ Secondary: ______________ Date of onset: ______________ **Please note that a cervical x-ray is required for riders with diagnosis of Down's Syndrome.*
Medical Concerns (please circle)	Health Status Cardiac Disease Incontinence Depression Circulation Muscle tone *Diabetic (insulin: yes no) *Epileptic (frequency of seizures?): ________ (date of last seizure): ________ Triggers: ______________
Behavioural Concerns (please circle)	withdrawal anxiety agitation aggressiveness (verbal / physical) depression delusions hallucinations paranoid smoking anger attention deficits
Sensory Concerns (please circle)	gait/ balance/coordination sensation concerns visual impairment auditory impairment ambulatory / non-ambulatory Sensory aids: ______________ Mobility aids: ______________
Communicable Disease	No: _____ Yes: ____ (please explain)______________
Allergies	No: _____ Yes: _____ (please list) ______________
Medications/specify use	
Surgery	No: ______ Yes: _____ Type of surgery: 1)______________ 2) ______________ 3) ______________ — Date(s): ______________
Other Concerns	

In my opinion, this patient can receive riding instruction under appropriate supervision. He/she may be evaluated further by the program therapist for evaluation of his/her physical abilities and or limitations in performing exercises and riding skills: yes / no.

Precautions/Contradictions: ______________

Referring Physician:

______________ ______________ ______________

Name/ Please print Signature Date

______________ ______________ ______________

Address Phone Fax

This document contains confidential information. If it is received in error please notify STRP immediately at (705) 560-7877. Thank you